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# OUT "SOONER AND SICKER": MYTH OR MEDICARE CRISIS?

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## HEARING BEFORE THE SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES NINETY-NINTH CONGRESS SECOND SESSION

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APRIL 10, 1986

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## OUT "SOONER AND SICKER": MYTH OR MEDICARE CRISIS?

THURSDAY, APRIL 10, 1986

HOUSE OF REPRESENTATIVES,  
SELECT COMMITTEE ON AGING,  
*Washington, DC.*

The committee met, pursuant to notice, at 1:30 p.m., in room 2167, Rayburn House Office Building, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present: Representatives Roybal, Synar, Vento, Frank, Wise, Gordon, Rinaldo, Tauke, Wortley, Schneider, Bentley, Fawell, Schuette, and Spence.

Staff present: Fernando Torres-Gil, staff director; Gary Christopherson, health legislation director; Nancy Smith, professional staff; Austin Hogan, communications director; Carolyn Griffith, staff assistant; Diana Jones, staff assistant; Valerie Batza, staff assistant; Marilyn Kunzweiler, detailee; and Margaret McNamara, intern.

### OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. The committee will come to order.

Today's hearing will examine the perceived and real problems surrounding the Medicare beneficiary who becomes ill enough to require hospitalization and, in some cases, post-hospital care. Specifically, we will examine issues surrounding sooner and sicker hospital discharges and the resultant need for nursing home and home-health care.

While today's hearing focuses on the impact of containing health care provider costs, we must not lose sight of the negative impact which past Medicare and Medicaid cuts have had and will continue to have on the elderly's health care cost burden. To alert my colleagues and the public to this very concern, I am releasing the committee's study documenting the elderly's already unacceptable out-of-pocket costs. I can assure you that this study will be in the hands of every Member of the House before the April 15 budget resolution deadline.

On the issues surrounding quality and excess, family members and friends of Medicare beneficiaries, as well as beneficiaries themselves, continue to write to my colleagues and to myself. While leaving many questions still unanswered, the March report of the inspector general of the Department of Health and Human Services adds credence to these concerns by stating, and I quote: "Based on the findings of this inspection—by the inspector general—it is

apparent that occurrences of premature discharges and inappropriate transfers do exist and must continue to be addressed aggressively by the Health Care Financing Administration and the Peer Review Organizations."

In today's hearing, we will examine the problems of Medicare patients being discharged from the hospital sooner and sicker, and being unable to access the post-hospital nursing home and home-health care they require.

Today, we once again will express our deep concern that Medicaid and Medicare budget cuts and other actions threaten the elderly's access to quality health care, and push their out-of-pocket costs toward dangerously high levels. Today, we call for Federal action: One, to limit elderly out-of-pocket health care costs to no more than 15 percent of income; and two, to upgrade quality and access protection for America's almost 30 million Medicare beneficiaries.

[The prepared statement of Chairman Roybal, along with additional material submitted by the Chairman, follows:]

## OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Today's hearing will examine the perceived and real problems surrounding the Medicare beneficiary who becomes ill enough to require hospitalization and, in some cases, post-hospital care. During the course of the hearing, the Committee will examine quality and access issues surrounding "sooner and sicker" hospital discharges and the resultant increased need for nursing home and home health care.

Before we begin, I want to preface this hearing with an important, cautionary note. While today's hearing focuses on the potential negative impact of containing health care provider costs, we must not lose sight of the negative impact which past Medicare and Medicaid cuts have had and will continue to have on the health care cost burden borne by this nation's nearly 30 million elderly.

To alert my colleagues and the public to this concern, I am releasing the new 1991 Committee projections of out-of-pocket health care costs. My intention is to have the information on the elderly's already unacceptable out-of-pocket costs in the hands of every member of the House before the April 15th budget resolution deadline.

The Committee's projections document that the elderly face out-of-pocket costs growing twice as fast as their incomes. By 1991, the elderly will have to use 18.5 percent of their income for health care -- much higher than the 12 percent spent in 1977 or the 15 percent spent when Medicare and Medicaid began. Tragically, these increases will occur even without further Medicare and Medicaid cuts.

These unacceptable increases result from past Medicare and Medicaid cuts and from the failure to control health care costs for the elderly consumer. As for the future, I am totally opposed to any Federal budget action which would add to what is already an excessive financial burden. In the long run, Congress must find ways to reduce this intolerable burden.

On the issues surrounding quality and access, family members and friends of Medicare beneficiaries, as well as beneficiaries themselves, continue to write to my colleagues and myself. They detail serious problems in being discharged 'sooner and sicker' from the hospital, without access to adequate care in the community. For these elderly patients and their families, this experience is frustrating, frightening, and may even be threatening to the patients' health or, most tragically, their lives.

We have grave concerns that beneficiaries are not being adequately protected and that the problem involves more than just isolated incidents or hospitals making initial adjustments to the new Medicare DRG prospective payment system. We have major concerns that in all our searching there is still relatively little data available on the impact of Medicare cost containment.

However, there is one study which all of you should note. While leaving many questions still unanswered, the March report of the Inspector General of the Department of Health and Human Services adds credence to those of us who have been pushing the quality and access issues these past years. To quote the Inspector General's March 1986 report:

"Based on the findings of this inspection (by Inspector General) it is apparent that occurrences of premature discharges and inappropriate transfers do exist and must continue to be addressed aggressively by the Health Care Financing Administration (HCFA) and the Peer Review Organizations (PROs)."

It is clear now that the incentives in Medicare's DRG prospective payment system have reduced significantly the time Medicare patients are spending in the hospital. The critical questions are 1) how many beneficiaries who are sick enough to need hospital care are being forced to leave "too soon and too sick," and 2) can they get the nursing home and home health care they need, when they are forced to leave the hospital early. I hope that this hearing will move us closer to having an answer to those questions which are essential to the Congress' making wise choices on upcoming Medicare issues.

As most of you know, the House Aging Committee has a long standing interest in these issues and has examined these issues in two previous hearings. Since those hearings, there have been several major changes with respect to Medicare: Gramm-Rudman-Hollings cuts in Medicare payments to hospitals and physicians, reductions in hospital reimbursement rates, and actions to reduce expenditures for nursing home and home health care. In addition, we've had almost another full year of experience with the DRG prospective payment system for hospital care.

Looking beyond these cost containment changes at the quality of health care issue, we may finally be seeing some progress. A new scope of work has been approved for Medicare's Peer Review Organizations. Legislation has been introduced and is being developed to strengthen Medicare's quality assurance system. Among the bills under consideration is a comprehensive quality and access reform package which I introduced in February--the Medicare Continuing Care Equity and Quality Assurance Act (H.R. 4330). My bill would upgrade the quality assurance system for the entire Medicare system and protect beneficiary access to home health and nursing home care. I am pleased to see that Congressman Stark is prepared to introduce an important quality assurance bill as well.

As a result of all these changes, I believe that it is time to re-examine the Medicare program, not just in terms of Federal government costs, but also in terms of the out-of-pocket costs of 30 million Medicare beneficiaries and their access to quality health care.

Today we will examine the problem of Medicare patients being discharged from the hospital "sooner and sicker" and being unable to access the post-hospital nursing home and home health they require.

Today we once again express our deep concern that Medicare and Medicaid budget cuts and other actions threaten the elderly's access to quality health care and push their out-of-pocket costs toward dangerously high levels.

Today we call for Federal action to 1) limit elderly out-of-pocket health care costs to no more than 15 percent of income and 2) to upgrade quality and access protection for America's 30 million Medicare beneficiaries.



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ELDERLY OUT-OF-POCKET HEALTH CARE COSTS PROJECTED TO RISE TO 18.5 PERCENT OF INCOME BY 1991 — MUCH HIGHER THAN THE 12.3 PERCENT IN 1977

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SIGNIFICANTLY MORE OF ELDERLY INCOME SPENT ON HEALTH CARE TODAY THAN WHEN MEDICARE AND MEDICAID BEGAN IN 1966

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Under the direction of Chairman Edward R. Roybal, the House Select Committee on Aging has completed an analysis of health care costs for America's aged. The results of that study clearly show that the elderly in 1986 are significantly worse off in terms of health care costs than they were in the 1977-1980 period. While the elderly's health care costs were just over 12 percent of their income in the 1977-1980 period, the elderly will be spending just over 16 percent of their already limited income in 1986 -- an average of \$1,850 per person.

- Elderly out-of-pocket health care costs in 1986 will be about \$1,850 per person — an average annual increase of 11.4 percent since 1980. The percentage of elderly income spent on health care has risen from 12.7 percent in 1980 to just over 16 percent in 1986.

Unfortunately, the worst is yet to come. Though the elderly's health care payments are already too high at 16 percent of income, health care payments will cost the elderly 18.5 percent of their income by 1991. In 1991, health care will cost an elderly person \$2,633 on the average.

- Compared to the 15 percent the elderly were paying for health care when Medicare and Medicaid began, the elderly will have to give up substantially more in the future. By 1991, they will be paying 18.5 percent of their income for health care.
- On the average, persons over 65 will pay more than \$2,633 in out-of-pocket health expenses by 1991. This compares to only \$712 in 1977, \$966 in 1980, and \$1526 in 1984.

Over the period from 1984 to 1991, the elderly's health care payments will rise at a rate about **twice as fast as their income**. Specifically, the elderly's share of health care costs are estimated to climb at a rate of 8.1 percent, while elderly income is expected to increase at an annual rate of only 4.0 percent.

Cutting Medicare and Medicaid and failing to contain health care costs has taken a devastating toll on the elderly's financial resources. Assuming that the elderly should not be required to use a greater percentage of their income than they did in 1980, program cuts and the failure to control health care costs have increased the elderly's health care payments in 1984 by nearly \$4.5 billion -- an added **\$160** per elderly person. Every year that there is a failure to control the elderly's share of health care costs, America's elderly will get deeper and deeper into trouble. Looking ahead to 1991, this failure will add \$26.9 billion to the elderly's health care burden -- an added **\$828** per elderly person.

- If elderly individuals were paying the same percentage of their income in 1984 and 1991 as they were in 1980, their health care payments would be \$160 less in 1984 and \$828 less in 1991. The total additions to elderly payments are nearly \$4.5 billion in 1984 and \$26.9 billion in 1991.

By the year 1991, the elderly will be using 18.5 percent of their income for health care -- a tremendous rise from the 12.3 percent in 1977 and the 12.7 percent in 1980. This increase results from relatively uncontrolled health care cost inflation and past Medicare and Medicaid cuts. This massive increase will occur even without any further cuts in Medicare and Medicaid. Unless action is taken to control health care costs generally, health care will continue to eat up ever larger portions of the elderly's income through 1991 and beyond.

Unfortunately, many people still believe that health care costs paid by the elderly are not excessive. Proposals continue to surface which would severely cut Medicare and Medicaid benefits. These proposals must be rejected in favor of actions which attack rapidly rising health care costs for States, the employer, the poor, the elderly -- not just for the federal portion of Medicare and Medicaid.

No one discounts the problem which the Federal government faces with increasing Medicare and Medicaid program costs. However, everyone must also recognize the immensity of health care costs paid by the elderly and the access problems of the poor. **Congress must cautiously and reasonably constrain health care costs for everyone. At the same time, we must carefully shield the elderly and poor from those Medicare and Medicaid cuts which increase elderly out-of-pocket costs or reduce access to quality health care.**

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\* NOTE: The Committee analysis and projections do not include the impact of the recent Consolidated Omnibus Budget Reconciliation Act.

The Committee analysis relies heavily on budget information provided by the Health Care Financing Administration as well as two HCFA studies: "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984" (Fall, 1984) and "Projections of health care spending to 1990" (Spring 1986).



COMMITTEE FINDINGS

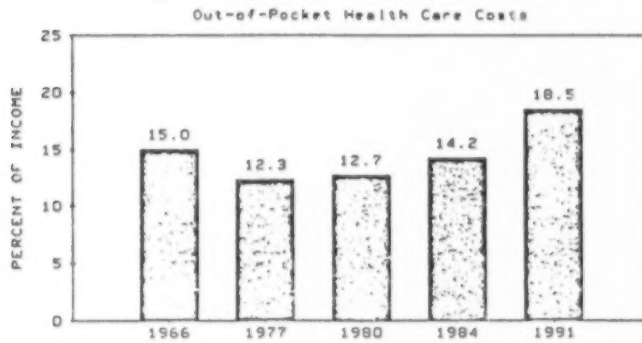
## ELDERLY HEALTH CARE COSTS RISING TWICE AS FAST AS INCOME THROUGH 1991

- The elderly's financial burden will grow even faster in the 1984-1991 period than in the 1977-1984 period. Between 1984 and 1991, the elderly's health care payments will rise twice as fast as their income.
- As compared to the 15 percent the elderly were paying for health care when Medicare and Medicaid began, they will have to give up substantially more in the future. By 1991, they will be paying 18.5 percent of their income for health care.
- If the elderly were paying the same percentage of their income in 1984 and 1991 as they were in 1980, their health care payments would be \$160 less in 1984 and \$828 less in 1991.
- Per capita payments by the elderly for health care will more than triple between 1977 and 1991 from \$712 annually to an estimated \$2,633 annually.
- Between 1977 and 1991, the elderly's health care payments will rise on average of 9.8 percent annually while their income will rise only an average of 6.5 percent.
- In 1984 and 1991, the elderly will pay about 40 percent of their health care. Due to Medicare copayments and coverage limitations, the elderly in 1991 will end up paying a much larger percentage of the costs of physician care (54%), nursing home care (56%), and drugs and other care (66%).

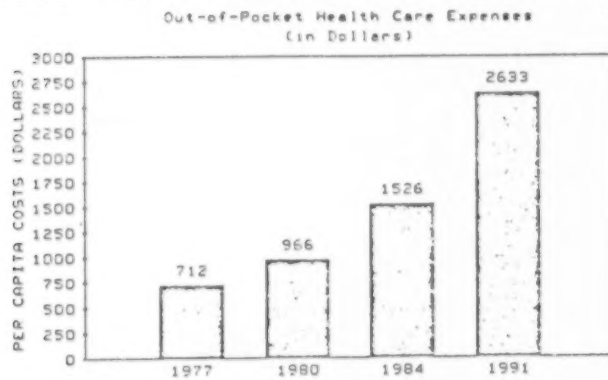
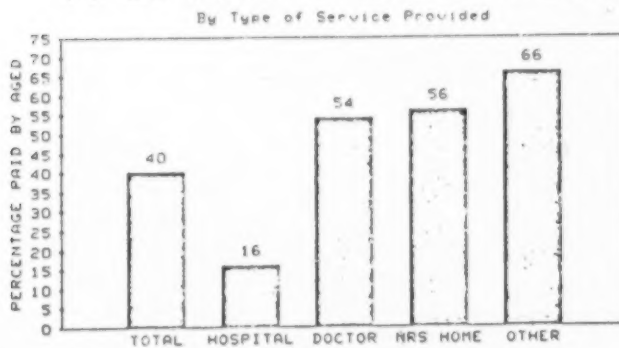
## ELDERLY'S HEALTH CARE BURDEN HIGHER THAN SIX YEARS AGO

- Elderly out-of-pocket health care costs in 1986 will be about \$1,850 per person -- an average annual increase of 11.4 percent since 1980. The percentage of elderly income spent on health care has risen from 12.7 percent in 1980 to just over 16 percent in 1986.
- The percentage of elderly income spent for health care was 14.2 percent in 1984 -- substantially higher than the figure of 12.7 percent in 1980. From 1977 to 1980, there was little change in this percentage.
- From 1980 to 1984, the elderly's health care costs grew at an annual rate of 12.1 percent while their income grew at the slower rate of 9.0 percent -- a 3.1 percent difference annually.
- During the 1977-80 period, the growth in elderly health care payments (10.7 percent annually) was in better balance with growth in elderly income (9.0 percent annually -- a difference of only 1.7 percent).
- In 1977, the elderly were paying just over 12 percent of their income for health care. This was a substantial improvement over the 15 percent paid in 1966 -- before Medicare and Medicaid were fully implemented.
- In 1986, the elderly are using more of their income for health care than when Medicare and Medicaid began in 1966.

## ELDERLY HEALTH CARE COSTS

AGED HEALTH CARE COSTS  
AS PERCENT OF INCOME

## AGED PER CAPITA HEALTH CARE COSTS

PERCENT OF HEALTH CARE COSTS  
TO BE PAID BY AGED IN 1991

Source: House Select Committee on Aging, April 1986;  
U.S. Bureau of the Census, April 1986; Health Care  
Financing Administration, July 1984 & April 1986.

PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE AGED 65 AND OLDER  
IN 1977, 1980, 1984 AND 1991

| SOURCE OF FUNDS   | PER CAPITA HEALTH EXPENDITURES |       |       |       |
|-------------------|--------------------------------|-------|-------|-------|
|                   | 1977                           | 1980  | 1984  | 1991  |
|                   | \$                             | \$    | \$    | \$    |
| Total             | 1,785                          | 2,515 | 4,157 | 6,638 |
| Private           | 719                            | 976   | 1,543 | 2,659 |
| Consumer          | 712                            | 966   | 1,526 | 2,633 |
| Out-of-Pocket     | 522                            | 721   | 1,072 | 1,789 |
| Insurance         | 115                            | 148   | 308   | 553   |
| Medicare Premiums | 75                             | 96    | 146   | 291   |
| Other Private     | 7                              | 10    | 17    | 26    |
| Government        | 1,066                          | 1,540 | 2,614 | 3,979 |
| Medicare          | 713                            | 1,061 | 1,832 | 2,879 |
| Medicaid          | 249                            | 333   | 543   | 760   |
| Other Government  | 104                            | 146   | 239   | 340   |

PERSONAL HEALTH CARE EXPENDITURES AS A PERCENTAGE OF INCOME  
FOR PEOPLE AGED 65 AND OLDER IN 1977, 1980, 1984 AND 1991

| ELDERLY CONSUMER<br>COSTS AS<br>PERCENTAGE OF<br>INCOME | YEAR   |        |        |        |
|---------------------------------------------------------|--------|--------|--------|--------|
|                                                         | 1977   | 1980   | 1984   | 1991   |
| % of Mean<br>Income                                     | 12.30% | 12.68% | 14.17% | 18.50% |
| % of Median<br>Income                                   | 18.46% | 18.53% | 21.40% | -      |

Consumer Cost / Mean Income:

1977 --  $712/5,853 = 12.30\%$   
 1980 --  $966/7,614 = 12.68\%$   
 1984 --  $1,526/10,774 = 14.16\%$   
 1991 --  $2,633/14,232 = 18.50\%$

Consumer Cost / Median Income:

1977 --  $712/3,856 = 18.46\%$   
 1980 --  $966/5,213 = 18.53\%$   
 1984 --  $1,526/7,131 = 21.40\%$

SOURCES: House Select Committee on Aging, April 1986; Census Bureau, April 1986; Health Care Financing Administration, July 1984 and April 1986.

INSPECTION OF  
INAPPROPRIATE DISCHARGES  
AND  
TRANSFERS

RICHARD P. KUSSEROW  
INSPECTOR GENERAL

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March, 1986

## MAJOR FINDINGS

- o Based on the findings of this inspection, it is apparent that occurrences of premature discharges and inappropriate transfers do exist and must continue to be addressed aggressively by the Health Care Financing Administration (HCFA) and the Peer Review Organizations (PROs).
- o During 10/1/83 - 5/31/85, HCFA reported 4,724 cases of premature discharges and inappropriate transfers. Yet, only 2,688 (57%) of the reported cases could actually be found. This is due to the phasing out of the Medical Review Entities (MREs), inconsistent instructions given by HCFA, and inaccurate reporting by the PROs. Another 1,018 cases were reviewed, of which 282 were reported after 5/31/85 and 736 had never been reported (See chart on page 9.) Also, during the time frames mentioned above, 14 (30%) of the PROs were not reporting premature discharges or inappropriate transfers. Therefore, the overall extent of the problem is still not fully known.
- o Of the 3,706 cases reviewed, 3,336 (90%) were referred by the PROs; 370 (10%) were referred prior to PRO implementation. One hundred and fifty-seven (4%) of the 3,706 cases were not inappropriate discharges or transfers. Of the remaining 3,549 cases, 2,907 (82%) were premature discharges, 491 (14%) were inappropriate transfers, and 151 (4%) could not be categorized by type.
- o Quality issues ranging from very minor to gross and flagrant were identified by the PROs in 2,146 (60%) of the 3,549 cases. PRO disposition of these cases ranged from intensified review of identified hospitals and physicians to no action being taken at all. In 927 (43%) of the cases with identified quality issues the only apparent action taken by the PRO was referral to HCFA.
- o Of the cases reviewed, medical records involving 133 patients were referred to OIG physician consultants for review. Nineteen were classified by OIG consultants as exhibiting gross and flagrant instances of substandard care. PROs took no corrective action, other than referral to HCFA, on 12 of these 19 cases. In the opinion of the OIG medical consultants, inappropriate actions were taken on 106 of the 133 cases. Thirty-eight of these cases have been returned directly to the PROs for various recommended

actions. The remaining cases are currently being reviewed by HCFA.

- o PROs did have the authority to take action on the quality issues identified in this study. It appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges and inappropriate transfers.
- o During OIG site visits conducted in September and December, 1985, problems were noted with the PRO's accumulation of data pertaining to the quality of care rendered by physicians and hospitals. This data is necessary for the identification of abusive patterns and subsequent corrective action.
- o HCFA has reviewed the recommendations contained in this report and concurs. It has already begun to correct a number of problems identified in the inspection. Details regarding HCFA's actions can be found in the appendix attached to this report. Also, increased sanction activity by the PROs against physicians/providers demonstrating abusive patterns of practice has been recently noted.



The CHAIRMAN. The Chair now recognizes Mr. Rinaldo.

**STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO**

Mr. RINALDO. Thank you, Mr. Chairman.

Mr. Chairman, the issue of Medicare cuts that we are addressing today deserves the full attention of Congress in the coming months. Our Nation's elderly are facing heavier financial burdens with ever-increasing health care costs, and reduced health care benefits should not be part of this problem and this burden.

One of the reforms to the Medicare system that I strongly believe should be pursued is the refinement of the prospective payment DRG system. In order to encourage efficiency in our Nation's hospitals, DRGs must reflect the cost of the care provided in order to be fair. These payments are calculated on the average. But if the payment is not fair and accurate, we may have shorter in-patient hospital stays with actually fewer services provided to the patient. This is not the type of reform envisioned by Congress when we passed the DRG legislation in 1983. We now have to assess whether the averages used reflecting the cost of care provided are accurate and meaningful and how they can be refined to better suit the needs of elderly patients.

Many problems have already occurred under the DRG system. In some cases, steps are being taken to remedy them. Senior citizens are afraid that they will not be treated for other problems that may crop up while they are hospitalized, for example. They are afraid of being discharged before they are cured; or being discharged prematurely and sent to a nursing home. Another fear is that of being sent home without adequate home health care. Finally, Medicare beneficiaries often do not know their rights under the DRG system, which include the right to appeal a discharge.

The Health Care Financing Administration has recognized this problem and has recently put together a letter for hospitalized Medicare recipients explaining the system and the patient's rights. This is a positive step toward helping beneficiaries understand and adjust to the DRG system.

We need to look at and examine carefully exactly how we can refine the DRG system to better implement its goals while preserving high quality care. Most importantly, I think an adjustment for the severity of illness within a DRG category needs to be explored.

The DRG system has merit. It is working in my home State of New Jersey, which implemented it before the Federal program. It is worth preserving. The problems with the system are not with the concept, but how the concept has been implemented.

I look forward, Mr. Chairman, to the testimony of the witnesses and their recommendations on how we can modify and reform the DRG system in the best interests of all Medicare beneficiaries.

Thank you.

The CHAIRMAN. Thank you, Mr. Rinaldo.

The Chair now recognizes Mr. Frank.

**STATEMENT OF REPRESENTATIVE BARNEY FRANK**

Mr. FRANK. Thank you, Mr. Chairman.

In lieu of a statement from myself, I am going to read a statement that was submitted to me for inclusion in the record. I do not ordinarily read one in its entirety. I hope the reason will soon become clear as to why I am on this one.

This is from the Massachusetts Association of Older Americans, Inc., and it is from the chairperson of the board of directors of the Massachusetts Association of Older Americans, Inc., Elsie Frank, my mother.

More and more older Americans have become uneasy about the prospects of good medical care. The present Administration thinks that the prime Medicare problem is saving money rather than trying to guarantee seniors the same high quality medical care in the future that we have enjoyed in the past.

The right to health care is a moral right. We elders are fearful of future illness with good reason, because we have not succeeded in repudiating the philosophy of what is the cheapest way to keep us alive. Frankly, I am concerned that fear of future illness will create paranoia.

Science has devised methods, machines, and medicine to prolong life that were unimaginable just 25 years ago. This has given us a new lease on life, enabling us to live on for many full years. But to what avail, if we senior citizens who have been blessed with longer life are now deemed a burden on society? Even now, with our numbers continuing to grow, elders in this country are under attack and a life-boat ethic is taking hold. With the cost cutting out of bounds, we are replacing the whales as an endangered species.

By now, it is common knowledge that the DRG system for paying hospitals is creating strong pressure for hospitals to discharge elderly patients as soon as possible. Hence, the phrase quicker and sicker has come into common usage.

Dr. Otis Bowen, Secretary of Health and Human Services, in a recent letter to the New York Times wrote: 'The prospective payment system and Peer Review Program was designed to improve the viability of the trust fund and, at the same time, safeguard the quality of care.' If Dr. Bowen can boldly state that the quality of care has not declined since the advent of the DRGs, then he is living in 'Never Never Land.'

The DRG system has unquestionably had a negative impact on elders and there is a subtle change in attitude for those of us on Medicare, exhibited by hospital personnel. Because of the DRG system in the name of cost containment, hospitals are giving Medicare patients the barest minimum. We elders must be watchful to make sure that the DRGs do not undercut humane and effective delivery of needed medical services for those of us on Medicare. We must make sure that cost-cutting temptations to the detriment of patients are resisted.

Health care policy has historically been controlled by hospitals, insurers, and businesses. Elderly advocates are determined to make some changes in that pattern and are demanding to be heard.

In his book entitled *American Health Revolution*, Joseph Califano states: "Medicare and Medicaid became the ultimate money tree to the providers. Government issued a license to steal by allowing Medicare to reimburse hospitals on a cost plus basis." Now that the horse has been stolen, the barn door has been locked by the imposition of the DRG system for those of us on Medicare. Besides encouraging hospitals to discharge patients quicker and sicker, there is a danger that hospitals will discriminate by admitting those Medicare patients with higher DRG allowances that the hospital felt it could treat for less than the DRG rate; or discharge patients when the DRG is used up.

I urge your committee to take a hard look at the problems of health care quality and access the elderly now face as a result of cost containment and the fact that while elderly patients are being discharged quicker and sicker from hospitals under the DRG system of payment, the administration's cost containment efforts are also limiting the access of the elderly to home health and nursing care which they need more than ever.

Medicare cost control must not come from the pockets and pocketbooks of older Americans and must not interfere with the elderly's access to quality care.

If we do not impose values on ourselves and the world around us, then some set of values will be imposed by future events, whether we like it or not. Some critical issues must be answered, such as what criteria will be used to decide who gets future health care. Is it going to be a clinical assessment of dollars and cents? Will age be a factor? Will our government's health policy influence decisions as to who will get health services; i.e., will the people who are economically better off be able to get them and the poor not get any?

During my lifetime, health care has changed from a cottage industry to a profitable monopoly, and health care costs have been allowed to rise with unchecked immunity. Older Americans must continue to speak out because it is not only our quality of life that must be considered, but future generations. We elders are not seeking special treatment to the detriment of the rest of society. All we ask for is fairness.

Thank you, Mr. Chairman. And maybe you feel the elocution lessons were worth something.

The CHAIRMAN. Thank you, Mr. Frank. Will you please express the committee's appreciation for the statement that Mrs. Frank has sent.

The CHAIRMAN. May I just say that I believe the statement she has submitted is a lot better than any statement than I think you would have made.

Mr. FRANK. Thank you, Mr. Chairman.

The CHAIRMAN. Now, may I ask you whether you agree with that or not?

Mr. FRANK. Well, I agree with the statement. That is why I made hers instead of mine, Mr. Chairman.

The CHAIRMAN. Thank you very much.

The Chair now recognizes Mr. Tauke.

#### STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Mr. TAUKE. Thank you, Mr. Chairman.

It is hard to follow Mrs. Frank. But I will say that her son probably read it twice as fast as she would have.

Mr. Chairman, I have a written statement that I ask unanimous consent to submit for the record.

The CHAIRMAN. Without objection, it will be the order.

[The prepared statement of Representative Tauke follows:]

## PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Mr. Chairman, I commend you for convening this hearing on access to care and quality of care under the Medicare prospective payment system. As are many other Members of Congress, I am receiving deeply disturbing reports from Medicare beneficiaries and their families of admissions denials and of premature discharges. Our goal as health care policymakers must be to ensure that Medicare beneficiaries continue to have access to high-quality, affordable health care services, and to reach this goal, we must find a balance among quality of care, access to care, and affordability. This hearing will provide us with valuable information as we seek this balance in the prospective payment system.

I would like to share with you a letter I recently received which is typical of the reports of access and quality of care problems I am receiving from my constituents:

I would like to add my protest to the practice of not admitting people to hospitals who are in need of hospitalization and also the early dismissal of those who are not fully recovered...Last year, my mother underwent gall bladder surgery and was sent home four days later. Several days later, she had to be readmitted...After several more days, she was sent home again, collapsed within an hour, and died two hours later of a blood clot to the lung...

I realize that in many instances, reports of premature discharges and denied admissions stem from a misunderstanding of the system and a lack of awareness of the changes in health care technology and treatments which make shorter hospital stays and treatments in other care settings possible. But I think we have a serious and growing problem of quality and access on our hands. This is confirmed by a General Accounting Office study, by a study by the Office of Technology Assessment, by recommendations offered in the Prospective Payment Assessment Commission's recently issued 1986 report, and by testimony gathered at a number of Congressional hearings.

A number of measures have been introduced to address this problem through increasing the quality-control activities of the Peer Review Organizations and through ensuring that Medicare beneficiaries receive understandable information on their rights. I am encouraged that the Health Care Financing Administration has increased the emphasis upon quality-assurance activities in the new contracts it is now negotiating with the Peer Review Organizations and has issued a statement of Medicare beneficiaries' rights that hospitals will be required to provide to patients.

While these are important steps, they do not get at one of the major factors producing access and quality problems--the prospective payment system is not sensitive to a number of differences among hospitals, reducing the ability of many hospitals, in turn, to respond to individual patient differences and needs. This insensitivity is particularly clear and particularly damaging in the case of small rural hospitals.

Unless the prospective payment system is adjusted to address the characteristics of small rural hospitals, many will close, and the entire rural health care system will deteriorate. Rural hospitals provide not only community-based in-patient and out-patient care, they also serve as the hub for the delivery of other health care services. Physicians are very reluctant to locate and remain in areas without hospitals. Hospitals in rural areas frequently provide home health care services, nursing home care services, respite care programs, preventive health programs and services, and other health care services.

The prospective payment system is a numbers game. Hospitals are expected to offset losses on some DRG cases against profits on others. Rural hospitals have fewer total admissions than urban hospitals, and a higher percentage of rural hospital admissions are Medicare beneficiaries. In 1984, Medicare beneficiaries comprised 40 percent of rural hospital admissions and 34 percent of urban hospital admissions. In 1984, admissions declined 5.7 percent for rural hospitals, compared with two percent for urban hospitals. Rural hospitals are thus particularly dependent upon Medicare for revenues and are less able to balance losses against gains.

In its 1986 Report, the Prospective Payment Commission focuses upon the problems posed for small rural hospitals by the prospective payment system:

In particular, the financial vulnerability of small rural hospitals to fluctuations in volume and case mix has caused concern. For larger institutions, minor fluctuations in volume and case mix are less critical. Larger hospitals can average these fluctuations from year to year and over a large number of cases. Small rural hospitals cannot take advantage of this "law of large numbers." If such hospitals are located in relatively isolated areas, and a deteriorating financial position results in closure of the facility, Medicare patients' access to services may be severely compromised.



The Commission goes further, suggesting that Congress and the Secretary of Health and Human Services may have to explore modifications in the reimbursement system for small rural hospitals:

In the end, the Congress or the Secretary or both may have to determine whether it is appropriate to pay slightly more money or to pay differently to avoid insolvency among certain rural hospitals...It may be cost-effective for Medicare to pay slightly more or slightly differently for care in these hospitals if, by doing so, rural patients are not required to seek care in distant urban hospitals where the care is less accessible and more costly...

The Commission also focuses on another serious problem the prospective payment system poses for many rural hospitals--the urban/rural differential in labor and non-labor reimbursement. In April of 1984, I chaired a hearing of the Select Committee on Aging in Independence, Iowa, to gather testimony on the impact of the prospective payment system on the rural elderly's access to health care. Witness after witness pointed to the rural/urban differential as inequitable and poorly structured. In the West North Central Region, urban hospitals receive 25 percent more in labor cost reimbursement and a staggering 54 percent more in non-labor cost reimbursement. While wages may be somewhat lower in rural Iowa, they are not 25 percent lower than urban wages. It is even more difficult to comprehend the 54 percent differential when one considers that smaller rural hospitals do not have the same ability as urban hospitals to purchase in bulk for discounts and that utility rates and many other costs are at least as high in rural as in urban areas.

This differential is particularly hard on rural hospitals located near urban areas, competing in the same labor markets, and buying in the same supply markets. How a hospital fares under the prospective payment system should depend upon its ability to offer needed, high-quality, cost-effective services. In reality, how a hospital fares may well depend simply upon where it happens to be located.

The Prospective Payment Assessment Commission recognized the problems posed by the urban/rural differentials in its 1985 Report and underscores the urgency of addressing these problems in its 1986 Report, stating: "The current PPS adjustment for variation in labor costs treats all rural hospitals in a state as a single rural area. Such an adjustment ignores differences in labor costs between rural areas within a state and ignores the problems of 'border' rural hospitals which must compete with urban hospitals for labor.

Congress has also expressed an awareness of and concern about the impact of the urban/rural differentials on rural hospitals. The Social Security Amendments of 1983, which enacted the prospective payment system, and the Deficit Reduction Act of 1985 require the Secretary to study and report on a number of rural hospital issues. These issues include a study of whether separate standardized amounts for urban and rural hospitals should be maintained; a study of whether current labor market areas should be refined to better reflect differences among areas within a state and whether the prospective payment system is an appropriate system to pay for care in small rural hospitals.

I am deeply disturbed and concerned that to date, none of these reports has been issued. Another report on the revision of the clearly seriously flawed area wage indexes used in calculating labor cost reimbursement required by the Deficit Reduction Act of 1984 was issued after months of delay and only after I and a number of other Members of Congress put great pressure on the Health Care Financing Administration and the Office of Management and Budget to complete the study, release it, and implement the revised indexes.

These reports will provide the basis for reforms in the prospective payment system that will help to ensure the survival of rural hospitals providing needed, cost-effective, high-quality services.

In the interim, we must provide those rural hospitals located near urban areas and most seriously affected by the urban/rural reimbursement differentials with a means to demonstrate that their costs are comparable to those of nearby urban hospitals and to receive reimbursement increases. I have introduced legislation (H.R. 3767) to provide this urgently needed relief from the inequity of the rural/urban differentials for these hospitals. I believe that this legislation merits the support of every Member of Congress who recognizes that ensuring Medicare beneficiaries' access to high-quality, community-based health care services requires the correction of obvious inequities and problems in the prospective payment system.

Thank you for your attention to my comments.

Mr. TAUKE. I commend you for convening this hearing on access to care and quality of care under the prospective payment system. As are many other Members, I am receiving a lot of disturbing reports from Medicare beneficiaries and their families of hospital admission denials and premature discharges.

Our goal as health care policymakers must be to ensure that Medicare beneficiaries have access to high quality, community-based, affordable health care services. To reach this goal, we must find a balance among quality of care, access to care, and affordability in the prospective payment system.

This hearing will provide valuable information as we seek this balance.

I would like to share with you, Mr. Chairman, and other members of the committee a letter I recently received which is typical of letters that I have received, and also reports on access and quality of care problems that I am hearing about from my constituents. And I would like to read a portion of the letter.

The letter says: "I would like to add my protest to the practice of not admitting people to hospitals who are in need of hospitalization; and, also, the early dismissal of those who are not fully recovered.

"Last year, my mother underwent gall bladder surgery and was sent home four days later. Several days after that, she had to be readmitted. After several more days, she was sent home again, collapsed within an hour, and died 2 hours later of a blood clot to the lung."

I realize that in many instances reports of premature discharges and denied admissions stem from a misunderstanding of the system and a lack of awareness in medical technology and medical practice, which makes shorter hospital stays and treatments in alternative care settings possible. But I think we have a very serious and growing problem on our hands of quality and access. This is confirmed by a General Accounting Office study. Again it was confirmed by an Office of Technology Assessment study. It was confirmed by recommendations in the Prospective Payments Commission's recently issued 1986 report, and, of course, by testimony offered at several congressional hearings.

Congress has looked at several measures to address this problem through improving the quality assurance activities of the PROs, and providing Medicare beneficiaries with a clear written explanation of their rights under the prospective payment system. These are important steps, and I am encouraged to note that the Health Care Financing Administration has also taken some measures.

But what is even more crucially needed to address quality and access problems, it seems to me, are reforms in the prospective payment system to make it more sensitive to hospital differences so that hospitals, in turn, can be more responsive to individual patient differences. Such reforms, Mr. Chairman, are especially needed for rural hospitals.

The Prospective Payment Assessment Commission's recently issued 1986 report underscores the urgency of reforms in the prospective payment system to address the unique situation of rural hospitals. How a hospital fares under the prospective payment system should depend on its ability to offer high quality, cost effective

tive needed care. But in reality, how a hospital fares may well depend on where it is located, whether it is urban or rural; and, if rural, how close it lies to an urban area. Correcting this problem will help to ensure that the rural elderly continue to have access to a range of high quality, affordable health care services.

I look forward to the testimony, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Tauke.

The Chair recognizes Mr. Synar.

#### STATEMENT OF REPRESENTATIVE MIKE SYNAR

Mr. SYNAR. Mr. Chairman, I would ask unanimous consent that my statement be made part of the record.

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Representative Synar follows:]

#### PREPARED STATEMENT OF REPRESENTATIVE MIKE SYNAR

Mr. Chairman, I want to thank you for holding these hearings today and assembling a fine group of witnesses to provide the committee with information on health care cost containment and its affects on senior citizens, doctors and hospitals. I want to commend the Chairman for his leadership in initiating the analysis of health care costs for elderly.

It is clear from the results of the report that our elderly cannot withstand additional cuts in medicare. Just with inflation alone, senior citizens will have to absorb some increases. That's why it is particularly important to keep in mind the incomes of our elderly and what they are currently paying in out-of-pocket medical expenses during debate on the FY87 budget. Additional cuts in medicare will increase what senior citizens pay from their own pockets for health care and will limit their access to health care services.

We need to be mindful of the increasing cost of the medicare and medicaid programs, and seek ways to reduce those costs without compromising the quality of health care being provided to Americans which rely these programs.

Mr. SYNAR. I cannot add much to what Tom has already added in his excellent remarks. I would just say that I think this is an appropriate hearing because there are a lot of myths about the changing health care needs of our elderly. Today's report on out-of-pocket health costs clearly points to the fact that the demands and needs of our elderly with respect to health care are increasing, not decreasing, and that Medicare is not going to fill necessarily the gaps of those needs.

It is very plain that our elderly's out-of-pocket expenses are greater today than when Medicare started. It is also very clear that the elderly in rural America face even more pressing problems with the lack of health care, the lack of doctors, the lack of transportation, and the lack of access to health care facilities and other services.

These hearings are important. I think they are needed. And, hopefully, they will eliminate some of the myths that have been generated recently.

The CHAIRMAN. Thank you.

Mrs. Bentley.

#### STATEMENT OF REPRESENTATIVE HELEN DELICH BENTLEY

Mrs. BENTLEY. Thank you, Mr. Chairman. I would like to commend you on your efforts here today. We are looking at two very important issues as you said. One, early hospital dismissals of the elderly; and, two, budget cuts in Medicare. These areas very defi-



nately will drastically affect elderly health care in the years to come.

As a Congresswoman, I have already seen the effects of rising health care costs in my district. My constituents are worried, and so am I. America's elderly cannot afford to spend over 16 percent of their limited incomes on health care costs, especially when many elderly are no longer receiving COLAs.

As for the second area we are addressing today, early hospital discharges, I have here several constituent cases from my district in Maryland to prove that these cases do exist. In fact, one of my constituents, Mrs. Mary Naper, of Dundalk, MD, had out-patient surgery for removal of blockage in eight blood vessels. The total procedure lasted 1½ hours. She was then released immediately from the hospital to go home. Upon arriving home, her veins ruptured, causing severe bleeding. Mrs. Naper had to be rushed back to the hospital, this time with a more serious problem. She could have died.

I ask unanimous consent to include her letter and that of another constituent.

The CHAIRMAN. Without objection, it will be the order.

[Letters from constituents of Mrs. Bentley follow:]

The Honorable Congressmen  
Mrs Helen Bently

FEB 24 1986

My Wife and I Live At 1417 Dundalk  
Ave. 21222

My Wife Blacked Out 3 Times Saturday  
Feb. 1st 1986. I Called Dr. FIROZVI  
and Had Her Sent By Ambulance To  
Church Hospital.

My Wife Was In Bed From Feb. 1st To  
Feb. 6th Without Getting Out of Bed.  
When I Was Ordered To Take Her Home.  
I Have 3 Insurances Medicare, Blue Cross  
and Aetna Insurance. I Do Not Think  
This Was Fair As I Am 81 Yrs Old  
and My Wife 71 Yrs Old.

We Do Not Blame Dr. Firozvi For It Was  
The Hospital Rule.

My Wife Was Very Upset That She Had To  
Leave 6:30 PM Feb. 6th For The Reason  
She Was Unable To Walk.

633  
8763

THANK YOU Very Much  
Mr. & Mrs. WELZIE MUMAW  
1417 DUNDALK AVE.  
BALTO MD. 21222

William P. Naper  
6916 Fifth Ave.  
Baltimore, MD. 21222

The Honorable Helen D. Bentley  
House of Representatives  
Washington D.C. 20515

OCT 28 1985

Dear Mrs. Bentley

On Friday October 11th. my wife, Mary J. Naper, entered Greater Baltimore Medical Center as an out-patient for removal of eight blocked Varicose blood veins. Mary was operated at 12:30 P.M. and released at 2:00 P.M.

Upon arriving at our home there was a rupture of the veins, not of our fault, which caused much bleeding and could have caused her death. We immediately contacted Dr. Geary Stonesifer, who told us to return to the hospital.

At the hospital I asked why and how this bleeding occurred and was told that The Medicare Program considers this type of operation as an out-patient basis. This is contrary to the doctor's opinion, who stated that this type of operation requires in-patient care.

It is our opinion, Why must we Senior Citizens suffer because of the short sightness of The Medicare Health Program cuts ?? We are asking you, Mrs. Bentley, for your co-operation to bring this matter to their attention.

Thanking you, and wishing you many more years of Good health and continue to be our fine representative in Congress.

Sincerely Yours,  
*William P. Naper*  
William P. Naper

Mrs. BENTLEY. I have long been concerned over this arbitrary rule of Medicare regarding the period of time a person should be hospitalized for each illness. This rule takes no consideration of the individual, their age, health, et cetera. An 80-year-old cannot and should not be classified under the same regulations as a 30-year-old. For these reasons, I would like to urge the committee to make a strong stand against existing rules and regulations on this matter.

Mr. Chairman, I anticipate an informative hearing today, and would like to welcome our fine panel of witnesses.

Thank you.

The CHAIRMAN. Thank you, Mrs. Bentley.

The committee greatly appreciates the fact that the other members of the committee have asked unanimous consent that their statements be included in the record at this point. And, without objection, that will be the order.

[The prepared statements of Representatives Pepper and Snowe follow:]

## PREPARED STATEMENT OF REPRESENTATIVE CLAUDE PEPPER

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE. DISTINGUISHED GUESTS. I AM PLEASED THIS COMMITTEE IS CONVENING A HEARING TO EXAMINE WHAT LIES AHEAD FOR SENIOR CITIZENS IN THEIR SEARCH FOR ADEQUATE HEALTH CARE AT A TIME WHEN THE ADMINISTRATION WILL BE RECOMMENDING FURTHER CUTS IN THE PROGRAM IN COMING YEARS. HOPEFULLY, THIS HEARING WILL SEND A CLEAR MESSAGE TO THE CONGRESS THAT THE PEOPLE OF AMERICA WILL NOT TOLERATE FURTHER CUTS. INDEED, OUR MISSION IN COMING MONTHS IS MUCH MORE NOBLE -- WE WILL BE CONSIDERING WAYS IN WHICH WE CAN IMPROVE THE BENEFITS CURRENTLY AVAILABLE UNDER THE MEDICARE PROGRAM EXPANDING IT TO COVER THE REAL CATASTROPHES OF LONG DRAWN OUT ILLNESSES CURRENTLY UNCOVERED BY FEDERAL OR PRIVATE INSURANCE PLANS.

IN AN EFFORT TO CONTROL SPIRALING HEALTH CARE COSTS, THE CONGRESS ESTABLISHED 3 YEARS AGO A NEW SYSTEM FOR PAYING FOR HOSPITAL CARE PROVIDED TO MEDICARE BENEFICIARIES. THIS NEW "DRG" SYSTEM HAS HAD A PROFOUND IMPACT ON THIS NATION'S HEALTH CARE SYSTEM. PERHAPS MOST IMPORTANTLY, IT HAS SERVED TO MAGNIFY AND FOCUS ATTENTION ON A NUMBER OF DEFICIENCIES IN OUR ENTIRE HEALTH CARE SYSTEM. IT HAS FORCED US TO EXAMINE PROBLEMS AND SEEK OUT SOLUTIONS. FOR EXAMPLE:

WE ARE FORCED TO EXAMINE CARE PROVIDED IN OUR NATION'S HOSPITALS.  
WE HAVE FOUND:

- o PATIENTS ARE BEING DISCHARGED "QUICKER AND SICKER" WITHOUT COMMUNITY SUPPORTS AVAILABLE -- AND HOME CARE IN SHORT SUPPLY. TODAY, 5 MILLION PEOPLE IN NEED OF HOME CARE ARE NOT GETTING SUCH CARE BECAUSE OF RESTRICTIVE DEFINITIONS OF THE HOME CARE BENEFIT. HOME CARE DENIALS TODAY REFLECT THE DISABILITY DENIALS SEVERAL YEARS AGO.
- o PEOPLE ARE DENIED TREATMENT AT PRIVATE HOSPITALS BECAUSE THEY CAN'T AFFORD IT AND ARE DUMPED IN PUBLIC HOSPITALS WHICH ARE HARD PRESSED TO PICK UP THE BILL.

WE ARE FORCED TO EXAMINE THE CARE PROVIDED IN OUR NATION'S 15,000 NURSING HOMES SERVING 1.5 MILLION ELDERLY. WE HAVE FOUND THAT:

- o AS A RESULT OF THE NEW DRG SYSTEM, NURSING HOMES ARE HAVING TO CARE FOR OLDER, SICKER AND MORE DEPENDENT PEOPLE. YET, PARTLY BECAUSE OF CUTBACKS OF OVER \$3 BILLION IN MEDICAID AND BILLIONS MORE IN MEDICARE, LESS SKILLED CARE IS AVAILABLE. IN 1984, SKILLED NURSING HOME RESIDENTS RECEIVED ONLY ABOUT 1 HOUR OF CARE A DAY BY NURSES, LESS THAN ONE HALF MINUTE BY DOCTORS. THE BULK OF CARE IS PROVIDED BY ILL TRAINED AND UNDERPAID NURSES' AIDES.
- o A RECENT REPORT BY THE NATIONAL ACADEMY OF SCIENCE'S INSTITUTE OF MEDICINE CONFIRMED THE SUBCOMMITTEE FINDINGS THAT ABUSE AND NEGLECT OF NURSING HOME PATIENTS IS THE INCREASING RESULT OF CUTBACKS. HOPEFULLY, THE IOM REPORT WILL RESULT IN NEEDED PROTECTIONS FOR OUR MOST VULNERABLE CITIZENS.

WE ARE FORCED TO EXAMINE THE CARE PROVIDED IN THE COMMUNITY. WE FOUND THAT:

- o 5 MILLION PEOPLE IN NEED OF IN HOME CARE ARE NOT GETTING THE CARE BECAUSE OF THE ADMINISTRATION'S RESTRICTIVE DEFINITIONS OF HOME CARE. ONE WITNESS BEFORE OUR SUBCOMMITTEE, A BLIND DIABETIC WHEELCHAIR BOUND AMPUTEE, TOLD US SHE WAS DENIED HOME

-2-

BECAUSE SHE HAD TO BE DRIVING TO A HOSPITAL FOR DIALYSIS THREE TIMES A WEEK, AND THEREFORE WAS NOT CONSIDERED HOMEBOUND.

- o THE DEMAND FOR IN-HOME SKILLED NURSING CARE HAS INCREASED NEARLY 200 PERCENT, HOUSEKEEPING SERVICES 70 PERCENT AND IN-HOME PERSONAL CARE 60 PERCENT SINCE THE IMPLEMENTATION OF THE NEW DRG SYSTEM.
- o PERHAPS NOWHERE IS THE INADEQUACY OF OUR CURRENT SYSTEM SO GROSSLY DISPLAYED AS IN THE CARE FOR 4 MILLION VICTIMS OF ALZHEIMER'S DISEASE. THERE IS NO "DRG" FOR ALZHEIMER'S DISEASE VICTIMS. IN FACT, MEDICARE PROVIDES NOTHING FOR THESE PEOPLE. A FAMILY IN NEW YORK, WITH SAVINGS OF \$200,000 CAN BE COMPLETELY WIPED OUT IN 48 MONTHS DUE TO THE COSTS ASSOCIATED WITH THIS UNCOVERED DISEASE.

WE ARE FORCED TO EXAMINE THE WASTE, FRAUD AND ABUSE THAT HAS RESULTED FROM NEW COST-CONTAINMENT INITIATIVES. WE HAVE FOUND THAT:

- o HOSPITALS ARE SIMPLY SHIFTING CERTAIN PROCEDURES OUT OF THE HOSPITAL WHICH IS CONTROLLED BY THE DRG PAYMENT SYSTEM TO THE OUT-PATIENT SECTION OF THE SAME HOSPITAL WHERE COSTS ARE NOT CONTROLLED. CATARACT SURGERY IS A PRIME EXAMPLE OF THIS MOVEMENT. OUR SUBCOMMITTEE FOUND THAT WE PAY ABOUT \$2400 FOR CATARACT SURGERY IN THE HOSPITAL AND UP TO \$5400 FOR THE SAME PROCEDURE IN THE SAME HOSPITAL PERFORMED BY THE SAME DOCTOR IN THE OUTPATIENT SECTION OF THE HOSPITAL. THIS PROCEDURE ALONE REPRESENTS A LOSS TO THE GOVERNMENT OF ABOUT \$1.2 BILLION A YEAR.
- o JOSEPH CALIFANO, FORMER SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TESTIFIED BEFORE OUR SUBCOMMITTEE LAST MONTH THAT AS MUCH AS \$.20 OF EVERY MEDICARE DOLLAR IS WASTED.

WHAT CAN BE DONE?

- o FIRST, WE MUST REJECT ANY SUGGESTIONS TO INCREASE THE FINANCIAL BURDEN OF THE ELDERLY UNDER THE MEDICARE PROGRAM;
- o SECOND, WE SHOULD CONSIDER THE MEANS BY WHICH THE MEDICARE PROGRAM MIGHT BE IMPROVED TO NOT ONLY ENSURE ITS SOLVENCY BUT IMPROVE ITS BENEFIT STRUCTURE. A COMPREHENSIVE CATASTROPHIC HEALTH INSURANCE PROGRAM IS NOT ONLY TIMELY -- IT IS THE NECESSARY RESPONSE.

THERE MUST BE MAJOR CHANGE. I BELIEVE THAT WE MUST BEGING TO LOOK BEYOND THE ACUTE AND INSTITUTIONAL BIASES OF OUR CURRENT HEALTH CARE SYSTEM TO THE AVAILABILITY OF PREVENTATIVE AND COMMUNITY CARE. IT IS IMPERATIVE THAT WE NOT ACCEPT A SHORT-SIGHTED RESPONSE TO OUR CURRENT HEALTH CARE CRISIS WHEN THE OPPORTUNITY FOR A MAJOR OVERHAUL IS NOW POSSIBLE.

THANK YOU.



## PREPARED STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

THANK YOU MR. CHAIRMAN. I COMMEND YOU FOR HOLDING THIS HEARING ON THE ISSUE OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS) AND ITS IMPACT ON OLDER PERSONS.

AS WE ARE ALL AWARE, THE COST OF HEALTH CARE IN THIS COUNTRY HAS BEEN INCREASING PRECIPITOUSLY. IN 1982, PRIOR TO THE IMPLEMENTATION OF PPS, THE FEDERAL GOVERNMENT WAS SPENDING OVER \$55 BILLION ON HOSPITALIZATION UNDER THE MEDICARE PROGRAM ALONE. AFTER THE IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM IN 1983, THE NUMBER OF DAYS OF HOSPITALIZATION DROPPED FROM 9.5 TO 7.7 AND THE NUMBER OF ADMISSIONS DECREASED. THE OVERALL COSTS FOR HOSPITAL EXPENDITURES IN 1986 INCREASED AT A SLOWER RATE TO A TOTAL OF \$49 BILLION. THERE IS CONCERN, HOWEVER, THAT COST CONTAINMENT HAS BEEN ACHIEVED WITHOUT ADEQUATE SAFEGUARDS FOR THE CARE THAT PATIENTS MAY BE RECEIVING.

UNDER THE PROSPECTIVE PAYMENT SYSTEM (PPS), HOSPITALS THAT SPEND LESS THAN THE FIXED FEE CAN KEEP THE PROFITS, AND THOSE THAT SPEND MORE MUST ABSORB THE LOSSES. THUS, THE INCENTIVE HAS CHANGED SO THAT HOSPITALS ARE DISCHARGING PATIENTS EARLIER, PERFORMING FEWER INPATIENT TESTS, AND SHIFTING SOME SURGERY TO OUTPATIENT CENTERS. MORE PATIENTS ARE USING HOME AND COMMUNITY BASED CARE IN AN EFFORT TO MAINTAIN THEMSELVES OUTSIDE OF THE HOSPITAL. ADDITIONALLY, NURSING HOMES ARE INCREASINGLY FILLED WITH ACUTE CARE PATIENTS DISCHARGED FROM HOSPITALS WHO NEED HIGHER LEVELS OF CARE AND MAY BE DISPLACING LONG-TERM CHRONIC CARE PATIENTS.

WHILE NONE OF THESE CHANGES IN THE SYSTEM IS INTRINSICALLY RISKY FOR THE INDIVIDUAL, THERE HAS BEEN GROWING CONCERN THAT MEDICARE PATIENTS MAY BE FACING PREMATURE RELEASE FROM HOSPITALS. THERE IS SOME SUGGESTION THAT, AS A RESULT OF PREMATURE DISCHARGE, SOME ELDERLY PATIENTS MAY BE QUICKLY READMITTED TO THE HOSPITAL IN A REVOLVING DOOR PATTERN OF CARE. IN AN EFFORT TO PREVENT SUCH OCCURRENCES, I INTRODUCED H. CON. RES. 221 WHICH WOULD ASSURE THAT MEDICARE PATIENTS ARE INFORMED ABOUT THEIR MEDICARE BENEFITS

DURING THEIR PERIOD OF HOSPITALIZATION. I HAVE ALSO WRITTEN TO SECRETARY BOWEN TO ASSURE THAT THIS INFORMATION IS MADE AVAILABLE TO BENEFICIARIES AT THE TIME THEY SIGN UP FOR MEDICARE AND AS CHANGES IN THE SYSTEM OCCUR.

IN MAINE I HAVE HEARD FROM NUMEROUS MEDICARE PATIENTS WHO INDICATE THAT THEIR PROBLEMS HAVE BEEN MORE IN THE AREA OF ACCESS BECAUSE OF DENIAL OF ADMISSION TO A HOSPITAL. ONE EXAMPLE WAS THAT IN WHICH A VERY ELDERLY WOMAN WAS DENIED ADMISSION TO THE HOSPITAL AFTER A FALL IN HER HOME. SHE WAS TREATED IN THE EMERGENCY ROOM FOR A BROKEN COLLARBONE AND THEN WAS RELEASED EVEN THOUGH SHE WAS CONFUSED AND LIVED ALONE.

CLEARLY, THERE ARE MANY QUESTIONS TO BE ANSWERED. WE NEED BETTER INFORMATION ABOUT THE WAY IN WHICH THE SYSTEM IS FUNCTIONING AND THE EXTENT TO WHICH QUALITY OF CARE IS BEING PROTECTED FOR THOSE ON MEDICARE. WE NEED TO BETTER EVALUATE SEVERITY OF ILLNESS UNDER THE DRGs. AND WE NEED TO LEARN HOW TO REFINE THE DRGs SO THAT THEY CAN ALLOW FOR NON-MEDICAL COMPLICATIONS WHICH MAY SERVE TO THREATEN THE SAFETY OF OLDER PERSONS AND TO CALL INTO QUESTION THE EFFICACY OF THE SYSTEM.

MR. CHAIRMAN, I THINK IT IS CLEAR THAT THE DRG SYSTEM NEEDS FURTHER STUDY AND REVIEW IN AN EFFORT TO ASSURE THAT OLDER PERSONS RECEIVE THE BEST POSSIBLE CARE WHILE AT THE SAME TIME ASSURING THE COST OF THAT CARE IS CONTAINED. I LOOK FORWARD TO HEARING TODAY'S TESTIMONY AS WE SEEK TO IMPROVE THE PROSPECTIVE PAYMENT SYSTEM.

The CHAIRMAN. I would like to take this opportunity to welcome the newest member of the committee, the gentleman from South Carolina, Mr. Spence.

Mr. Spence has served in the Congress of the United States for many years. He is one of the most effective Members of the House. And he has been a tremendous addition to this committee. He well knows that this committee is made up of four subcommittees, and I am sure that he will select a subcommittee where he will be most active. And the end result, of course, will be that his work in that subcommittee and in this full committee will be most beneficial not only to the committee itself, but to the people that this committee is designed to serve.

I welcome you, Mr. Spence. And if you have a statement to make——

I yield to Mr. Rinaldo.

Mr. RINALDO. I just want to join you in your comments and welcome Congressman Floyd Spence, who I am certain will make an important contribution to this committee and be a real asset as we continue our deliberations into this and other problems affecting the elderly. It is good to have him here.

Mr. SPENCE. Thank you, Mr. Chairman. I am pleased to be here. I hope I can make a contribution and that I can learn something. Thank you.

The CHAIRMAN. Thank you, Mr. Spence. I am sure that you can and that you will. Welcome to the committee.

I would like to call on the first witness, and that is a young man who has been the acting administrator of the Health Care Financing Administration since February 1986. He is relatively new to the Finance Administration. We know that he has a difficult job, and we are looking forward to working with you, doctor, in the years to come.

Will you please proceed, Dr. Desmarais, in any manner that you may desire.

#### STATEMENT OF DR. HENRY R. DESMARAIS, ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. DESMARAIS. Thank you, Mr. Chairman.

My name is Henry Desmarais, and I am the acting administrator of the Health Care Financing Administration. I have been with the agency for a little over 3 years, although most recently as acting administrator.

I am pleased to join this committee in a discussion of the quality of care issues under prospective payment. I intend to summarize my testimony briefly, and ask that it be entered into the record in full.

To say the least, there have been some very revolutionary changes in the health care delivery system in this country, not the least of which has been the Medicare hospital prospective payment system.

Since hospitals had been accustomed to over 17 years of cost-base reimbursement, it should not surprise any of us that this kind of revolutionary change would result in a fair amount of anxiety, uncertainty, and begin to raise questions about whether quality of

care was being maintained or improved or changed in any way under such a changed reimbursement system.

Mr. Chairman, this hearing is entitled "Sooner and Sicker: Myth or Medicare Crisis." I would like to argue that myth or Medicare crisis are not the only two choices. And I would like to explain why I feel this way.

First, we take the word "sooner" or, in some parlance, "quicker." It certainly is true that this is not a myth; in fact, we do know that Medicare patients are being discharged earlier than they used to under cost-base reimbursement. That is not a surprise. It was fully expected by the Congress that passed the hospital prospective payment system and by the administration that implemented it. So, yes, length of stay has been decreased, and, in fact, there had been a historic trend toward a shorter length of stay in both the Medicare and non-Medicare programs. We knew this going in because there had been great variability across this country in the length of time patients stayed in the hospital. In one State, they might stay an average of 10 days for a particular condition, but in another State, for the same condition, the same kinds of patients might stay only 5 days. Many research people raised the question of why; why this variability and is it a reasonable variability.

The second point is whether patients are being discharged sicker. And certainly that word has very pejorative implications. I prefer to say that patients are being discharged and should be discharged as soon as they are well enough and no longer require hospital-level of care. In many instances, patients are being discharged to the care of nursing homes particularly skilled nursing facilities, and into the care of home health agencies. On this subject, I think we have to remember that the Medicare Program has an acute care orientation, has had it for 20 years, does cover home health and skilled nursing facility care. But that coverage is somewhat limited, and there are certain requirements that patients must meet in order to be covered under the program.

The fact that more patients are being discharged to nursing homes and home health raises the question of access, which is one of the questions that you have raised, Mr. Chairman.

I would like to point out that the total number of facilities available to care for Medicare beneficiaries continues to increase rather dramatically. For example, in the home health arena, in 1982, there were 3,639 Medicare-certified home health agencies in this country. Today I am happy to report that there are over 6,000 home health agencies serving Medicare beneficiaries.

With respect to skilled nursing facilities, Medicare-only certified facilities numbered 276 in 1982, and that has risen to 495. Facilities certified for both Medicare and Medicaid numbered 5,233 in 1982 and now are up to over 6,200 such facilities in 1986. In addition to the total number of facilities, the utilization, the number of home health visits, the number of visits per beneficiary, and total spending for these services continues to increase dramatically. For example, on the home health side in 1982, the Medicare Program was spending about \$1 billion for home health care; in 1985, we were spending over \$2 billion. And we project that by 1990 we will be spending approximately \$4 billion per year for home health care.

The issue of prospective payment also raises quality of care issues. And I would like to spend a bit of time talking about the multipronged strategy that we have used in the area of quality of care.

First, let me observe that the hospital prospective payment system, by its very nature, has incentives in it that will lead to improved quality of care. What exactly do I mean?

One of the things I mean is that prospective payment is causing hospitals to begin to specialize. They are no longer trying to do everything and do it infrequently. They are now trying to become more efficient and to specialize in certain procedures. And the old axiom is "practice makes perfect." We know that good quality flows from higher rates of doing individual procedures.

Similarly, the incentives are certainly not to have patients undergo unnecessary testing, unnecessary surgeries, or unnecessary treatments. Every treatment, every test, as a physician I know, each one of these has a certain risk associated with it. And the fact that prospective payment would discourage unnecessary utilization, again, should certainly reflect on good quality of care.

One of the elements that we have used to monitor quality of care and to try to assure its continuance is the Peer Review Organization system, which the Congress passed along with the hospital prospective payment system. These organizations do focus on quality of care. During each one of their contract negotiations issues of quality, issues of over-use or under-use of individual procedures and treatments were addressed, and they were to be monitoring for those kinds of events. In addition, the Peer Review Organizations today look for instances of premature discharge and, in fact, watch for readmissions within a seven-day period; and also look at transfers to determine whether any of those are the result of premature discharges.

The new scope of work for the next 2-year contract for our Peer Review Organizations will focus even more on quality of care issues. Each of the cases reviewed by Peer Review Organizations will be subjected to a generic quality screen. For example, they will look to see whether discharge planning was appropriate at the time of discharge; was the patient medically stable; did trauma occur during the hospital stay; did the patient acquire a nosocomial or hospital-acquired infection. If any of those events is seen to occur, the entire case will be reviewed very closely to determine whether there was a quality problem.

In addition, I would like to point out that the recently enacted Reconciliation Act increases the authority of Peer Review Organizations, and they now have the authority to deny payment in instances of substandard quality of care. This was a provision which the administration supported.

Well, all is not perfect. Our Peer Review Organizations in some instances are not doing what they were meant to do, and in some cases, they needed to acquire some experience before they could do a better job. Where we have uncovered poor performance, we have dealt with it, Mr. Chairman; we have terminated three Peer Review Organizations over the last 2 years. We have alerted a fourth that we intend to terminate for poor performance.



In addition, these are contractors of ours. They are no longer grantees. And we do require that they perform in order to continue to maintain the contract with us. And, in fact, we are now reviewing all of the Peer Review Organizations in this country to determine whether we should automatically renew their contracts or whether in fact we should open up individual areas to competitive bid once again.

The next prong of our quality of care strategy involves beneficiary education. And many of the members here today have already noted how important beneficiary education and understanding is.

It is a myth, Mr. Chairman, that there is such a thing as arbitrary limits or the fact that a DRG is up. That is a myth. Yes; there are average lengths of stay, but in most schools in this country—I would say all—an “average” means some are above and some are below. Unfortunately, there is an impression out there that if the average length of stay is 10 days everyone ought to be discharged in 9 days or less. That is a myth. And we would like to join this committee, as we have already, to educate beneficiaries, physicians, and providers about that particular myth. In fact, I am happy to report that one of the steps you have pointed out we have taken recently—each Medicare beneficiary at the time of admission is given an important message from Medicare, a message that I am happy to report we worked with the committee staff to develop. It outlines very clearly and succinctly a patient's rights of appeal, the function of the Peer Review Organizations, and what to do if a patient thinks they are being asked to leave too soon.

Another element in our quality of care strategy is a number of studies that we have commissioned, both in-house and by outside groups, to monitor the quality of care. Such respected organizations as the Commission on Professional and Hospital Activities, the Rand Corp., the Urban Institute, the Northwest Oregon Health Systems, and others are helping us to monitor and to perform studies within the area of quality of care.

Finally, I would like to say that we are pursuing many of the items which, for example, Mr. Rinaldo and Mr. Tauke pointed out today, refinements in prospective payment, being able to account better for differences in severity of illness and for the unique needs of rural hospitals. We are hard at work on those DRG refinements.

In summary, we share the committee's concern about quality of care and its maintenance. We are working to improve the performance of the Peer Review Organizations and the other elements of our quality of care strategy. There are instances of premature discharge. When they are uncovered, our Peer Review Organizations have the tools to deal with those. And we are working to ensure that they, indeed, live up to those responsibilities.

I would be happy to now take your questions.

[The prepared statement of Dr. Desmarais follows:]



PREPARED STATEMENT OF HENRY R. DESMARAIS, M.D., ACTING  
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

### INTRODUCTION

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM PLEASED TO BE HERE TODAY TO DISCUSS AN ISSUE OF THE UTMOST IMPORTANCE; THE IMPACT OF THE PROSPECTIVE PAYMENT SYSTEM (PPS) ON THE QUALITY OF CARE PROVIDED TO MEDICARE BENEFICIARIES. WE SHARE THIS COMMITTEE'S INTEREST IN ASSURING THAT MEDICARE IS ACHIEVING ITS GOAL OF PROVIDING, IN A COST EFFECTIVE MANNER, HIGH QUALITY SERVICES THAT ARE BOTH MEDICALLY NECESSARY AND APPROPRIATE.

### HEALTH CARE REVOLUTION

HIGH QUALITY MEDICAL CARE HAS A LONG-STANDING TRADITION IN THIS NATION. THE MEDICARE PROGRAM HAS PLAYED AN IMPORTANT ROLE BY ENSURING THAT HIGH QUALITY SERVICES ARE AVAILABLE TO OLDER AMERICANS.

TODAY, WE FACE A CHALLENGE TO MAINTAIN THAT TRADITION WHILE "APPLYING THE BRAKES" ON SPIRALING HEALTH CARE COSTS. THROUGH REFORMS AND REFINEMENTS, I BELIEVE WE ARE SEEING A CHANGE IN BEHAVIOR, A REVOLUTION IF YOU WILL, IN THE HEALTH CARE SYSTEM -- BOTH IN HOW SERVICES ARE DELIVERED AND IN HOW THEY ARE PAID. EVERYONE IS INVOLVED; CONSUMER, PROVIDERS AND THIRD PARTY PAYERS. CONSUMERS OF HEALTH CARE SERVICES ARE BECOMING WISER SHOPPERS, SPENDING THEIR HEALTH CARE DOLLARS WHERE THEY RECEIVE THE MOST BENEFITS; CORPORATIONS AND UNIONS ARE REVAMPING BENEFIT PACKAGES TO CONTAIN COSTS THROUGH USE OF HMOs AND EXPERT PANELS TO REVIEW AND PREDETERMINE WHAT SERVICES WILL BE COVERED AND AT WHAT LEVEL OF REIMBURSEMENT. INSURANCE COMPANIES ARE CHANGING THEIR FIRST DOLLAR COVERAGE PLANS TO INCLUDE DEDUCTIBLES AND COINSURANCE. THEY ARE ALSO ADVERTISING FLEXIBLE BENEFIT PLANS TAILORED TO MINIMIZE PREMIUM COSTS.

WE ARE ALSO SEEING FUNDAMENTAL CHANGES IN HOW HEALTH SERVICES ARE BEING DELIVERED. MORE PHYSICIANS ARE OPTING TO PROVIDE SERVICES UNDER SALARIED ARRANGEMENTS THROUGH THEIR INVOLVEMENT IN HMOs AND

GROUP PRACTICES RATHER THAN UNDER THE TRADITIONAL FEE-FOR-SERVICE MECHANISM. PHYSICIANS ARE BECOMING ACUTELY AWARE OF THE COSTS OF HEALTH CARE SERVICES AND TECHNOLOGIES THEY ORDER FOR PATIENTS AND ARE BEING ASKED TO MAKE JUDGEMENTS ON THE NECESSITY OF MARGINAL SERVICES. CHANGES ARE BEING SEEN IN HOSPITALS AS THEY DEVELOP MORE COST EFFECTIVE METHODS FOR PROVIDING SERVICES -- ESPECIALLY SERVICES INVOLVING HIGH TECHNOLOGY PROCEDURES. THERE IS EVIDENCE OF A DECREASE IN ANCILLARY SERVICES WITHIN HOSPITALS. THERE IS AN INCREASED SHARING OF SERVICES AND EQUIPMENT BETWEEN PROVIDERS, INCREASED SPECIALIZATION OF CASES WITHIN HOSPITALS WHICH ARE BEST EQUIPPED TO HANDLE THEM, AND GREATER COMPETITION AMONG HOSPITALS. IN ADDITION, THE DOWNWARD TREND IN LENGTH OF STAY, WHICH BEGAN IN 1969, CONTINUES.

#### PROSPECTIVE PAYMENT SYSTEM

AN INTEGRAL PART OF THIS "REVOLUTION" IN THE HEALTH CARE SYSTEM IS THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS). THERE ARE FEW WHO WOULD NOT AGREE THAT THE PPS WAS AN INNOVATION IN REIMBURSEMENT METHODS WHOSE TIME HAD COME.

FOR OVER 17 YEARS, HOSPITALS WERE REIMBURSED BY MEDICARE ON A REASONABLE COST BASIS WHICH FAILED TO ENCOURAGE EFFICIENCY IN THE UTILIZATION OF SERVICES AND SUPPLIES SINCE WE REIMBURSED BASICALLY WHATEVER COSTS WERE INCURRED. UNDER PPS, HOSPITALS ARE ENCOURAGED TO PROVIDE ONLY THOSE SERVICES WHICH ARE MEDICALLY NECESSARY, TO MORE EFFICIENTLY MANAGE ALL OF THEIR RESOURCES AND TO PROVIDE CARE IN THE MOST APPROPRIATE SETTING.

THERE ARE A NUMBER OF POSITIVE EFFECTS FOR BENEFICIARIES, PROVIDERS AND THIRD PARTY PAYERS WHICH RESULT FROM A PROSPECTIVE SYSTEM. SOME THAT READILY COME TO MIND ARE:

- O BENEFICIARIES ARE PROTECTED FROM INCIDENTS OF UNNECESSARY HOSPITALIZATION, UNNECESSARY SURGICAL INTERVENTION AND POSSIBLE RESULTING INFECTION;
- O BENEFICIARIES ARE RECEIVING CARE IN MORE APPROPRIATE SETTINGS; IN AN OUTPATIENT DEPARTMENT, IN A SKILLED NURSING FACILITY (SNF) OR AT HOME THROUGH ARRANGEMENTS WITH A HOME HEALTH AGENCY (HHA).

I WOULD LIKE TO TAKE A MOMENT HERE TO SPEAK BRIEFLY ABOUT SNF AND HHAS. THESE POST-ACUTE BENEFITS ARE IMPORTANT COMPONENTS OF THE MEDICARE PROGRAM. BY PROVIDING MEDICARE COVERAGE OF ACUTE HOSPITAL, SNF AND HOME HEALTH CARE, CONGRESS RECOGNIZED THAT IN THE TREATMENT OF ILLNESS, VARYING LEVELS OF CARE WERE OFTEN APPROPRIATE IN ORDER TO ENSURE CONTINUITY OF CARE.

THE VERY PURPOSE OF THE MEDICARE SNF AND HHA BENEFITS HAS ALWAYS BEEN TO AVOID PROLONGED HOSPITALIZATION AND TO PROVIDE SERVICES TO THOSE BENEFICIARIES WHOSE CARE NEEDS ARE BELOW THE ACUTE HOSPITAL CARE LEVEL, BUT WHOSE CONDITIONS ARE SUCH THAT THEY ARE UNDER THE CARE OF A PHYSICIAN AND IN NEED OF SKILLED NURSING CARE. PATIENTS ARE DISCHARGED FROM ACUTE CARE HOSPITALS TO SNFS OR HHAS ON A PHYSICIAN'S ORDERS AND THE CARE IN THESE SETTINGS MUST BE PRESCRIBED BY A PHYSICIAN, THUS ENSURING THE CONTINUITY OF PHYSICIAN OVERSIGHT.

THERE IS CONTINUING CONCERN THAT MEDICARE BENEFICIARIES ARE BEING DISCHARGED FROM THE HOSPITAL BEFORE THEIR CONDITION WARRANTS. THERE IS NO DOUBT THAT UNDER THE COST REIMBURSEMENT SYSTEM, HOSPITALS AND PHYSICIANS WERE INCLINED TO KEEP PATIENTS IN THE HOSPITAL LONGER THAN UNDER THE PPS -- LONGER PERHAPS THAN WAS NECESSARY. IN FACT, THE UNIVERSAL BELIEF THAT THIS WAS INDEED THE CASE, WAS ONE OF THE FACTORS THAT PROMPTED THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION LEGISLATION TWELVE YEARS AGO AND THE ORIGINAL PEER REVIEW ORGANIZATION LEGISLATION (THE PRO LEGISLATION WAS MODIFIED LATER TO ADDRESS PPS REIMBURSEMENT). THE OVERALL INTENT OF BOTH OF THESE PIECES OF LEGISLATION WAS TO ASSURE THAT MEDICARE BENEFICIARIES RECEIVED THE APPROPRIATE CARE IN THE APPROPRIATE SETTING.

THERE IS LITTLE DOUBT THAT THE OPERATION OF PPS HAS INCREASED THE LIKELIHOOD THAT SOME PATIENTS WILL RECEIVE POST-HOSPITAL SERVICES AT A POINT IN THEIR RECOVERY WHERE THAT CARE IS APPROPRIATE. THIS IS EXACTLY WHAT WE'RE SEEING UNDER PPS. WHILE PPS HAS INCREASED INCENTIVES TO SHORTEN HOSPITAL STAYS, SUB-ACUTE CARE IS APPROPRIATELY BEING PROVIDED IN SNFS AND HHA WHERE NECESSARY.

WE ARE SEEING AN INCREASE IN THE NUMBER OF SNFS AND HHAS IN RESPONSE TO PATIENT NEED. THE PERCENTAGE INCREASE IN SNF ADMISSIONS FOR THE PERIOD 1983-1984 HAS BEEN ACCOMPANIED BY THE INCREASE IN CERTIFIED FACILITIES, BOTH HAVE INCREASED BY ABOUT 5 PERCENT. HOME HEALTH CARE IS ONE OF THE MOST RAPIDLY GROWING BENEFITS COVERED BY MEDICARE BOTH IN TERMS OF THE NUMBER OF BENEFICIARIES SERVED, THE NUMBER OF PATIENT VISITS AND THE INCREASE IN EXPENDITURES. FOR EXAMPLE, 1,190,000 BENEFICIARIES RECEIVED MEDICARE HOME HEALTH SERVICES IN 1982 COMPARED TO 1,520,000 IN 1984. SIMILARLY, THE NUMBER OF VISITS PER 1000 MEDICARE ENROLLEE INCREASED FROM 1060 IN 1982 TO 1330 IN 1984. HCFA EXPENDITURES FOR THESE SERVICES INCREASED FROM MORE THAN 1 BILLION DOLLARS IN 1982 TO OVER 2 BILLION IN 1985 AND IS PROJECTED TO REACH ALMOST 4 BILLION IN 1990.

THE GROWTH IN THE NUMBER OF PROVIDERS ALSO DEMONSTRATES THAT INCREASED DEMAND FOR THESE SERVICES IS BEING MET BY THE INDUSTRY. FOR EXAMPLE, THE NUMBER OF HHAS HAS INCREASED FROM 3639 IN 1982 TO 6012 SO FAR THIS YEAR. THE NUMBER OF MEDICARE ONLY CERTIFIED SNFS INCREASED FROM 270 TO 495 AND THE NUMBER OF DUALY CERTIFIED, I.E., MEDICARE AND MEDICAID SNFS, ROSE FROM 5233 TO 6243 DURING THIS SAME PERIOD.

WE BELIEVE THAT THESE MEDICARE BENEFITS ARE BEING ADMINISTERED IN A MANNER WHOLLY CONSISTENT WITH THE INTENT OF CONGRESS, BOTH IN THE STATUTORY LANGUAGE AND IN THE LEGISLATIVE HISTORY OF THE BENEFIT. WE ARE, HOWEVER, INTERESTED IN MAKING CERTAIN THAT THE PPS DOES NOT ENCOURAGE PREMATURE DISCHARGE. WE ARE ALSO INTERESTED IN UNDERSTANDING THE NEED FOR POST-HOSPITAL CARE AND THE AVAILABILITY OF THESE SERVICES TO MEDICARE BENEFICIARIES. I WILL SPEAK MORE ABOUT OUR ACTIONS RELATED TO BOTH OF THESE ISSUES IN A MOMENT.

TO RETURN TO THE POSITIVE EFFECTS OF PPS, THE HOSPITAL INDUSTRY IS ALSO BENEFITING:

- 0 HOSPITALS ARE REWARDED FOR CAREFUL UTILIZATION OF RESOURCES, AS THE SYSTEM ENCOURAGES MANAGEMENT TO ORGANIZE AND PROVIDE SERVICES IN AN EFFICIENT AND COST-EFFECTIVE MANNER;

O THE SYSTEM ENSURES GREATER PREDICTABILITY OF REVENUE FOR THE HOSPITAL. ALL EVIDENCE WOULD INDICATE THAT HOSPITALS ARE DOING VERY WELL UNDER PPS. ACCORDING TO A 1985 REPORT BY THE DEPARTMENT'S OFFICE OF THE INSPECTOR GENERAL, HOSPITALS EARNED AN HIGHER AVERAGE PROFIT IN MEDICARE PAYMENTS DURING THE FIRST YEAR OF PPS.

AND FINALLY, PPS REINFORCES THE ROLE OF THE FEDERAL GOVERNMENT AS A PRUDENT BUYER OF SERVICES.

LET ME EMPHASISE, THAT THE COMPLEXITY OF THE NEW PAYMENT SYSTEM AND ITS ACCOMPANYING MEDICAL REVIEW REQUIREMENT PRESENTED AN ENORMOUS CHALLENGE TO OUR DEPARTMENT. WE ARE WELL INTO THE THIRD YEAR UNDER PPS, AND THAT CHALLENGE REMAINS A PRIORITY. FURTHERMORE, WE ARE CONTINUING OUR ACTIVITIES TO REFINE AND MONITOR THE SYSTEM TO ENSURE THAT PAYMENT LEVELS SUPPORT DELIVERY OF HIGH QUALITY CARE. WE HAVE ALREADY MODIFIED THE WAGE INDEX USED TO ADJUST THE LABOR PORTION OF THE DRG RATES. WE ARE INVOLVED IN A COMPREHENSIVE RESEARCH EFFORT TO DETERMINE HOW TO RECOGNIZE DIFFERENCES IN SEVERITY AMONG PATIENTS WITH SIMILAR DIAGNOSES. WE ARE ALSO INVESTIGATING HOW TO DEAL EQUITABLY WITH RURAL HOSPITALS WHICH COMPETE WITH CLOSELY NEIGHBORING HOSPITALS IN URBAN AREAS.

WHILE PPS HAS ACHIEVED AND WILL CONTINUE TO ACHIEVE POSITIVE RESULTS, THERE ALSO EXISTS WITHIN THE SYSTEM -- AS IN ANY SERVICE OR PRODUCTION AREA -- INCENTIVES FOR PROVIDERS WHICH COULD HAVE AN ADVERSE IMPACT ON THE QUALITY OF PATIENT CARE. I WOULD LIKE TO SHARE WITH YOU TODAY, WHAT WE ARE DOING TO ASSURE THAT MEDICARE BENEFICIARIES ARE RECEIVING QUALITY CARE.

#### QUALITY OF CARE

THE MOST CRUCIAL OBJECTIVE THROUGHOUT THE PAYMENT REFORM PROCESS HAS BEEN TO MAINTAIN QUALITY AND ACCESS TO CARE FOR OUR BENEFICIARIES. TO ACCOMPLISH THIS, CONGRESS ENACTED A STRONG, MEDICAL REVIEW MECHANISM. THE PRO AMENDMENTS OF 1982 PUT THIS MECHANISM IN PLACE. BUT THE IMPLEMENTATION OF PROS WAS JUST THE BEGINNING. THIS MEDICAL REVIEW SYSTEM IS AS DYNAMIC AS IS THE PPS AND WE ARE CONTINUING TO REFINE BOTH SYSTEMS AS WE GAIN



EXPERIENCE. WE BELIEVE THAT PRUS WILL NOT ONLY CONTINUE TO ENSURE THAT QUALITY MEDICAL CARE IS DELIVERED IN THIS COUNTRY'S HOSPITALS BUT WILL ALSO ASSURE THAT PAYMENTS CONTINUE TO BE APPROPRIATE.

#### PRO SCOPE OF WORK

THE PRO'S SCOPE OF WORK FOR THE 1986-1988 CONTRACT PERIOD WAS DEVELOPED TO REFLECT THE KNOWLEDGE WE HAVE GAINED DURING THE FIRST TWO YEARS OF PRO REVIEW. THIS FIRST TWO YEARS' EXPERIENCE REVEALED THE NEED TO REFINE PRO EFFORTS IN THE AREA OF QUALITY OF CARE AND TO FURTHER FOCUS REVIEW ON POOR PERFORMING PROVIDERS AND PRACTITIONERS. THE PRO SCOPE OF WORK HAS BEEN EXPANDED IN THE FOLLOWING WAYS RELATIVE TO QUALITY OF CARE:

- O PRUS WILL BE REQUIRED TO SUBJECT EVERY CASE THEY REVIEW TO A GENERIC QUALITY SCREEN TO DETERMINE SUCH THINGS AS THE ADEQUACY OF DISCHARGE PLANNING;
- O PRUS WILL NOW BE REQUIRED TO REVIEW ALL READMISSIONS WITHIN 15 DAYS OF DISCHARGE AS OPPOSED TO WITHIN 7 DAYS AS REQUIRED IN THE FIRST PRO CONTRACT PERIOD;

IN ALL CASES WHERE A PRO FINDS POOR QUALITY, CORRECTIVE ACTION WILL BE TAKEN, RANGING FROM EDUCATION OF THE INDIVIDUAL PHYSICIAN OR HOSPITAL, TO INTENSIFIED REVIEW, TO PAYMENT DENIALS WHERE ACTIONS ARE TAKEN TO CIRCUMVENT PPS, AND ULTIMATELY TO EXCLUSION FROM THE MEDICARE PROGRAM.

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO THANK YOU, MR. CHAIRMAN AND THE MEMBERS OF THIS COMMITTEE, FOR YOUR SUPPORT OF THE COBRA PROVISION WHICH EXPANDS THE PRUS EFFECTIVENESS WITH THE AUTHORITY TO DENY PAYMENT FOR POOR QUALITY CARE, WHILE PROTECTING MEDICARE BENEFICIARIES.

#### PREMATURE DISCHARGE

AS I STATED EARLIER, A CONTINUING CONCERN OF BOTH CONGRESS AND THE ADMINISTRATION HAS BEEN THE POTENTIAL FOR PREMATURE DISCHARGE UNDER PPS. WE SHARE THE CONCERN THAT MEDICARE BENEFICIARIES SHOULD STAY IN THE HOSPITAL AS LONG AS NECESSARY. THE MEDICARE PROGRAM EMPHASIZES THAT PATIENTS SHOULD REMAIN IN THE HOSPITAL UNTIL THEY ARE WELL ENOUGH TO BE RELEASED. WE ARE AWARE THAT

THERE HAVE BEEN CASES OF PREMATURE DISCHARGE AND EVEN ONE CASE IS UNACCEPTABLE. WE ARE CONCERNED ABOUT ANY REPORTS OF MEDICARE BENEFICIARIES BEING RELEASED BY HOSPITALS BEFORE THEY ARE WELL ENOUGH AND WE ARE COMMITTED TO THE STRONGEST POSSIBLE ACTION WHEN WE LEARN OF ANY INSTANCES OF POOR QUALITY CARE. TO AUGMENT OUR CURRENT AUTHORITY, CUBRA PROVIDES US WITH ADDITIONAL AUTHORITY TO TAKE ACTION AGAINST HOSPITALS THAT INAPPROPRIATELY DISCHARGE OR TRANSFER MEDICARE BENEFICIARIES.

#### PATIENT'S RIGHTS

ANOTHER AREA THAT HAS CONCERNED US IS THE CONTINUING MISUNDERSTANDING BY SOME ABOUT PPS, PKU REVIEW AND THE RIGHTS OF PATIENTS TO AN APPEAL. ONE AREA OF CONFUSION TO MEDICARE BENEFICIARIES AND THEIR FAMILIES HAS BEEN THE MISUNDERSTANDING THAT A PATIENT MUST BE DISCHARGED ONCE THE "DRG IS UP." CLEARLY, THIS IS NOT THE CASE. THE PPS SYSTEM IS BASED ON PAYMENTS WHICH, ON AVERAGE FOR A DRG, WILL BE ADEQUATE TO COVER THE UTILIZATION OF SERVICES. SOME PATIENTS WILL HAVE STAYS BELOW THE AVERAGE, OTHERS ABOVE IT. IT IS THE RESPONSIBILITY OF THE HOSPITAL TO PROVIDE ALL NECESSARY SERVICES REGARDLESS OF THE LENGTH OF STAY. IN ORDER TO INCREASE BENEFICIARY UNDERSTANDING OF THIS FACT, WE HAVE INSTRUCTED ALL HOSPITALS TO GIVE BENEFICIARIES INFORMATION UPON ADMISSION ABOUT THEIR APPEAL RIGHTS. IN LATE FEBRUARY, A LETTER "AN IMPORTANT MESSAGE FROM MEDICARE" WAS PROVIDED TO ALL INTERMEDIARIES IN THE COUNTRY FOR DISTRIBUTION TO MEDICARE PROVIDERS WHO WILL DISTRIBUTE IT TO BENEFICIARIES. WE HAVE ALSO SENT INSTRUCTIONS TO PKUs CONCERNING THEIR MONITORING OF HOSPITAL COMPLIANCE ON THE DISTRIBUTION OF THIS INFORMATION TO BENEFICIARIES. IN ADDITION, WE ARE REVISING AND CONSOLIDATING THE PAMPHLETS WHICH EXPLAIN THE APPEALS PROVISIONS UNDER MEDICARE. WE ARE ALSO DEVELOPING A NEW PAMPHLET TO BETTER EDUCATE MEDICARE BENEFICIARIES AND THEIR FAMILIES REGARDING HOSPITAL STAYS UNDER PPS. THE 1986 EDITION OF YOUR MEDICARE HANDBOOK HAS ALREADY BEEN REVISED TO INCLUDE ADDITIONAL CURRENT INFORMATION ON A NUMBER OF RELEVANT TOPICS, INCLUDING APPEAL RIGHTS, TO ASSURE THAT THE INFORMATION IS FULLY CURRENT.

IN ADDITION, WE HAVE INCLUDED IN THE 1986-1988 PKU SCOPE OF WORK, A COMMUNITY OUTREACH PROGRAM TO HELP BENEFICIARIES UNDERSTAND THE ROLE OF THE PKU AND THEIR APPEALS RIGHTS. WE WILL ALSO CONTINUE TO WORK WITH GROUPS INTERESTED IN DEVELOPING INFORMATIONAL PUBLICATIONS ON THE APPEALS PROCESS.

WE BELIEVE THAT INFORMED CONSUMERS AND THEIR FAMILIES CAN DO A GREAT DEAL TO PROTECT THEIR OWN RIGHTS AND TO INFLUENCE THE EFFICIENCY OF THE HEALTH CARE SYSTEM. WE WILL USE EVERY AVENUE AVAILABLE TO US TO ASSIST OUR BENEFICIARIES IN BECOMING THEIR OWN BEST ADVOCATE.

#### MONITORING PRU PERFORMANCE

IN ADDITION TO THE REFINEMENTS WE HAVE MADE IN PPS AND PRU REVIEW, WE ARE CLOSELY MONITORING WHAT PPS AND PRU REVIEW ACTUALLY MEAN TO THE MEDICARE PATIENT. I WOULD LIKE TO STRESS THAT WE MONITOR THE PRU PROGRAM VERY STRINGENTLY AND TAKE PROMPT ACTION WHERE WE FIND DEFICIENCIES IN PERFORMANCE. ONE OF THE MOST IMPORTANT TASKS FOR US HAS BEEN TO ASSURE THAT PRUS ARE AGGRESSIVE IN DETECTING AND DEALING WITH PREMATURE DISCHARGE AND OTHER QUALITY PROBLEMS. BASED ON OUR EVALUATION OF THE PERFORMANCE OF THE 15 PRUS WHOSE CONTRACTS EXPIRE JUNE 30, 1986, WE HAVE HAD TO NON-RENEW 7 CONTRACTS. WE HAVE WITHHELD MONEY FROM SEVERAL PRUS BECAUSE OF POOR PERFORMANCE. IF THAT POOR PERFORMANCE IS NOT CORRECTED, WE WILL TERMINATE THAT PRU, AND HAVE IN FACT TERMINATED 3 PRUS SINCE THE IMPLEMENTATION OF PRUS IN JULY 1984.

IN ADDITION TO THE FUNCTIONS OF PRUS AND WHAT THEY TELL US ABOUT THE IMPACT OF PPS ON MEDICARE BENEFICIARIES, WE ARE INDEPENDENTLY LOOKING AT THIS IMPACT ON PATIENT CARE THROUGH 7 MAJOR QUALITY OF CARE EVALUATIONS.

ONE OF THESE STUDIES, BEING CONDUCTED BY OUR OFFICE OF RESEARCH AND DEMONSTRATIONS, IS TO DETECT BROAD PPS-RELATED EFFECT ON QUALITY OF CARE BY EXAMINING THE OUTCOMES OF HOSPITAL CARE ON THE HEALTH STATUS OF PATIENTS.

WE HAVE CONTRACTED WITH HEALTH CARE RESEARCH FIRMS FOR COMPLETION OF FOUR OTHERS:

- 0 A STUDY BY THE COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES TO MEASURE THE GENERAL EFFECTS OF PPS ON THE QUALITY OF INPATIENT HOSPITAL CARE, PRIMARILY BY EXAMINING CHANGES IN HOSPITAL USAGE AND TREATMENT PATTERNS AND THEIR EFFECTS ON INPATIENT AND DISCHARGE STATUS;

0 TWO STUDIES BY RAND CORPORATION:

- + A STUDY TO EVALUATE THE IMPACT OF PPS ON THE QUALITY OF CARE BY ASSESSING POTENTIAL EFFECTS ON CHANGES IN INPATIENT HOSPITAL TREATMENT PATTERNS THROUGH A THOROUGH EXAMINATION OF THE MEDICAL RECORD, AND RESULTANT HEALTH STATUS OUTCOMES; AND
- + A STUDY TO DEVELOP IMPROVED METHODS FOR MONITORING HOSPITALS ON AN ONGOING BASIS;

- 0 A STUDY BY THE URBAN INSTITUTE TO EVALUATE PPS QUALITY IMPACTS ON ESRD MEDICARE BENEFICIARIES, A SUBSET OF THE MEDICARE POPULATION GENERALLY ASSUMED TO REPRESENT AN UNUSUALLY HIGH MEDICAL RISK GROUP.

ADDITIONAL QUALITY OF CARE STUDIES INCLUDE:

- 0 A STUDY BY THE NORTHWEST OREGON HEALTH SYSTEMS, CURRENTLY UNDERWAY, TO DEVELOP A METHOD FOR MEASURING PATIENT HEALTH STATUS AT THE TIME OF HOSPITAL DISCHARGE. THIS STUDY WILL HELP US UNDERSTAND THE FUNCTIONAL STATUS OF PATIENTS AT DISCHARGE AND GIVE US SOME INSIGHT INTO THE TYPE OF PATIENTS WHO MAY REQUIRE POST-HOSPITAL CARE AND THE LEVEL OF THIS NEED. THIS INSTRUMENT CAN ALSO BE USED TO DETERMINE THE IMPACT OF PPS ON THE HEALTH STATUS OF PATIENTS AT DISCHARGE, AND;
- 0 A MAJOR STUDY IS ALSO BEING PLANNED BY HCFA, IN COORDINATION WITH ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE), TO DETERMINE THE NEED FOR POST-HOSPITAL SERVICES AND THE AVAILABILITY OF THESE SERVICES. THIS STUDY WOULD LOOK AT THE APPROPRIATENESS OF POST-HOSPITAL CARE SERVICES, POTENTIAL BARRIERS TO THESE SERVICES, PROGRAM AND BENEFIT COSTS AS WELL AS OUT-OF-POCKET COSTS FOR BENEFICIARIES.

WE EXPECT THAT THESE STUDIES WILL PROVIDE FURTHER INFORMATION ON:

- 0 WHERE PPS IS WORKING WELL;
- 0 HOW IT NEEDS TO BE CHANGED TO WORK BETTER;

- O HOW PRO REVIEW SHOULD BE FURTHER REFINED;
- O THE ACTUAL IMPACT OF PPS ON PATIENT HEALTH STATUS AND THE ACCESSIBILITY AND NEED FOR POST-HOSPITAL CARE.

#### MONITORING - SURVEY AND CERTIFICATION

OUR CONCERN FOR ACCESS AND QUALITY, HOWEVER, EXTENDS BEYOND PRO HOSPITAL REVIEW. WE HAVE A NUMBER OF MEASURES IN PLACE THAT FURTHER UNDERScore OUR COMMITMENT TO MAINTAINING THE HIGHEST POSSIBLE LEVEL OF QUALITY CARE. THE SURVEY AND CERTIFICATION PROGRAM PROTECTS THE HEALTH AND SAFETY:

- O OF BENEFICIARIES IN MEDICARE FACILITIES, SUCH AS HOSPITALS AND SNFS; AND
- O OF BENEFICIARIES WHO RECEIVE HOME CARE THROUGH A CERTIFIED HOME HEALTH AGENCY.

WE ARE STRENGTHENING THIS REVIEW BY:

- O MODIFYING THE SURVEY PROCESS FOR SNFS AND HHAS TO FOCUS MORE CLOSELY ON PATIENT OUTCOME.
- O REQUIRING STATE SURVEY AGENCIES TO BEGIN HOME VISITS TO DETERMINE THE EFFICACY OF CARE DELIVERED TO OUR BENEFICIARIES IN THE HOME SETTING, AND BY
- O STRENGTHENING MEDICAL REVIEW OF ADMISSIONS TO SNFS BY FISCAL INTERMEDIARIES.

ADDITIONALLY, FISCAL INTERMEDIARIES AND CARRIERS CONTINUE TO BE EVALUATED ANNUALLY TO ASSURE THAT MEDICAL REVIEW DETERMINATIONS ARE ACCURATE AND ARE IN CONFORMANCE WITH HCFA GUIDELINES AND INSTRUCTIONS. THESE CHECKS PROTECT OUR BENEFICIARIES FROM INACCURATE DETERMINATIONS BY THE INTERMEDIARIES.

#### CONCLUSION

IN CONCLUSION, WE ARE EXTREMELY PLEASED WITH THE PROGRESS OF THE PROSPECTIVE PAYMENT SYSTEM AND THE PERFORMANCE OF PEER REVIEW ORGANIZATIONS IN ASSURING THAT HIGH QUALITY CARE IS MAINTAINED. THIS SUCCESS IS SHARED BY PROVIDERS AND PHYSICIANS WHOSE EFFORTS CONTRIBUTED SIGNIFICANTLY TO THE SMOOTH IMPLEMENTATION AND CONTINUING OPERATION OF THE PROGRAM. AS WITH ANY INNOVATIVE PROGRAM, NO MATTER HOW WELL THOUGHT OUT, THERE ARE ALWAYS

ADDITIONAL IMPROVEMENTS THAT CAN BE MADE. WHEN WE DETERMINE THAT ACTION CAN BE TAKEN TO INCREASE THE HIGH QUALITY CARE BEING PROVIDED, WE WILL ACT PROMPTLY.

RESPONSIBILITY TO ENSURE QUALITY OF CARE, HOWEVER, DOES NOT REST SOLELY WITH THE GOVERNMENT. IT IS A RESPONSIBILITY WHICH MUST BE SHARED WITH PHYSICIANS, PROVIDERS AND CONSUMERS. WE LOOK FORWARD TO CONTINUED COOPERATION IN OUR SHARED GOAL OF ENSURING THAT EVERY PATIENT RECEIVES HIGH QUALITY, MEDICALLY NECESSARY CARE. I WILL BE HAPPY TO ANSWER ANY QUESTIONS.



The CHAIRMAN. Thank you very much, Dr. Desmarais.

The committee will now operate under the 5-minute rule, making it possible for each member of the committee to ask at least one, maybe two questions. And after that we will go into the 10-minute rule, followed by an additional 10 minutes of questioning per member.

You stated that the number of nursing homes has increased. Yet, in written testimony submitted to this committee by yourself, this was in July, you told us that the number had dropped from 2,493 to 2,422. Now, I realize that that is only a decrease of 71 nursing homes, but 71 nursing homes, where a great deal more are needed, that is a big drop. How can that be explained?

Dr. DESMARAIS. I am not sure what numbers you are referring to. Of course, this is my first appearance before this particular committee. And certainly the number of facilities are much higher with respect to nursing homes.

The CHAIRMAN. This is a hearing that took place July 9, 1985. You, of course, were not present. But we asked you and your Department to submit testimony.

But what I am asking now is regarding your statement today. You say that nursing homes have increased. How much have they increased since last July?

Dr. DESMARAIS. Well, I do not have those numbers. What I gave you was the fact that on the nursing homeside—now remember, the nursing homes that I referred to were the skilled nursing home facilities. And, certainly, that is the only benefit under the Medicare Program. There are also nursing homes, as you know, intermediate care facilities, and I did not refer to those. But for skilled nursing facilities, there are such nursing homes that are Medicare-only certified, and they increased from 1982 from 276 to 495 in 1986. Those that are both Medicare- and Medicaid-certified numbered 5,233 in 1982, and in 1986 numbered 6,243.

The CHAIRMAN. One other question. Dr. Bowen was quoted, as recently as Tuesday, as saying, and I quote him: "There is no evidence of any reduction in the quality of care as a result of Medicare cuts." Yet the inspector general's report states that they found at least 2,050 cases of premature discharges.

Will you respond to that?

Dr. DESMARAIS. Yes, Mr. Chairman.

I think first we need to think about the cause and effect issue. I am sure no one in this committee or elsewhere would suggest that all quality was perfect, that there were no premature discharges, and that there was no malpractice out in our hospitals. Certainly even prior to prospective payment system, there were problems. And as I have said quite clearly this morning, there are individual instances of premature discharge or quality problems today.

The CHAIRMAN. Then you do agree, then, that there are cases—

Dr. DESMARAIS. There are individual instances. But, systemically, we do not see a problem. We do not see a generic quality of care problem that one can attribute to the hospital prospective payment system. In fact, the incentives in that system would argue that in many instances quality would be even better today.

The CHAIRMAN. But the facts are that these 2,000 cases, and we know there are more than those 2,000, are individuals that have been released sooner and sicker. Is that something that you would acknowledge?

Dr. DESMARAIS. That's right. There are individual instances of premature discharge that have occurred. And, of course, the inspector general's report in large measure predated our Peer Review Organization system, and the additional authority that those organizations now have.

The CHAIRMAN. So the truth of the matter is that we do have a problem. And, Doctor, my 5 minutes are up.

The Chair now recognizes Mr. Rinaldo.

Mr. RINALDO. Thank you very much, Mr. Chairman.

I would like to ask if there are any plans within HCFA to implement the PRO system for outpatient and postdischarge care, since I am sure I am not alone when I state that many of the problem areas that have been brought to my attention from constituents in my district involve outpatient and postdischarge care. So is there anything being discussed or are there any plans being firmed up to implement a PRO system in those areas?

Dr. DESMARAIS. Our preference would be to improve the inpatient review being done by Peer Review Organizations rather than to expand their mandate into other areas. However, the answer to your question is not that simple.

The recently passed Reconciliation Act includes a provision that mandates the review of 10 elective surgical procedures. And there is some question among the lawyers as to whether those were intended to include outpatient surgical procedures in addition to inpatient procedures. We have not yet resolved that issue.

In addition, there is a provision in reconciliation to require—a provision dealing with Peer Review Organization review of HMO care. That is an area we are looking at to begin the implementation process.

We have no active plans to expand beyond that to include nursing homes or home health care, or other areas of outpatient care.

Mr. RINALDO. Well, you do not need a congressional mandate or legislative action to do that.

And, Mr. Chairman, I would like the record to remain open so that my question can be responded to after further discussion within HCFA as to what suggestions and recommendations you folks would make regarding some sort of system for inpatient and postdischarge care.

The CHAIRMAN. Without objection, that will be the order.

Mr. RINALDO. Thank you, Mr. Chairman. And I have no further questions.

The CHAIRMAN. The Chair now will recognize Mr. Wise. He has informed the Chair that he has no questions at this time. But I would like to acknowledge the fact that Mr. Wise, to my immediate right here, insisted that this hearing be held. I thank you for that effort.

The Chair now recognizes Miss Schneider.

Miss SCHNEIDER. Thank you, Mr. Chairman.

I wonder if you could tell us, Doctor, what is the procedure for following up on a claim of premature discharge once it has been referred to HCFA?

Dr. DESMARAIS. Well, it does not get immediately referred to the agency. The Peer Review Organization begins a process, and that process might include educating the physicians or the hospital that is involved. If that does not resolve the situation, they may issue warnings. In some instances, in just talking with the physicians, a physician may actually decide to no longer perform certain procedures for which they are not qualified. And they may actually suddenly realize that that is a problem they have.

If that does not work, Peer Review Organizations have the authority to deny payment and they may ultimately refer the issue to the inspector general, who may actually exclude them from the program or levy financial penalties.

Miss SCHNEIDER. Well, it seems to me that in terms of providing warnings or saying you are going to be educating the doctors, that is not terribly specific. And who has to take on that role of reprimanding the doctor? To whom is that referred?

Dr. DESMARAIS. The Peer Review Organizations are local physicians who are under contract to us to review the quality of care in hospitals. They may work with the medical staff and so on.

Ms. SCHNEIDER. So, essentially, we are saying that there is not a set procedure in place whereby such claims for premature discharge are processed; the—

Dr. DESMARAIS. There is a procedure. It—

Miss SCHNEIDER [continuing]. Peer review process will take place if they say, well, he is a good doctor; this is just one slip-up of early discharge, then perhaps they will just ignore it? Or is there really a process whereby the peers are required to say to the doctor, well, we have a problem here; we have this claim?

Dr. DESMARAIS. There is a process. They are to followup in every one of those instances. It just depends on the unique circumstances. If it is a flagrant violation, then certainly they move more aggressively to either deny payment or refer the issue to the inspector general. It depends on exactly what is going on and whether there is any misunderstanding or intentional abuse and so on.

Miss SCHNEIDER. Let me ask you something else.

In terms of the Medicare Continuing Care, Equity, and Quality Assurance Act, two of the provisions in there I would like to have your comment on. One of them creates uniform assessment criteria for claims review to ensure equal treatment in claim determinations within and across various intermediaries; for example, shifting from a hospital to a nursing home or to a hospice center.

What are your thoughts on that?

Dr. DESMARAIS. We are moving as quickly as we can in that direction as well. One of the things that we recently announced in the Federal Register for home health claims is that we were going to move toward only 10 fiscal intermediaries in the entire country who would handle all of those claims. That is a move in the direction of consistency.

We have changed the forms that home health agencies must use. They do not necessarily like those new forms. But the point I want to make is that our goal was to get the information consistently re-

ported so the same judgments could be reached, whether you were in one State versus another State. And we are doing similar things, both educating those who process those claims and simply improving our policies so they are clear.

But still, I think each patient is individual and it is not always easy to account for everything that you need to account for in order to achieve consistency.

Miss SCHNEIDER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Miss Schneider.

The Chair recognizes Mr. Frank.

Mr. FRANK. Thank you, Mr. Chairman.

I ask unanimous consent at this time to insert into the record some documents and an article from the secretary of elderly affairs of Massachusetts, Dr. Richard Rowland; an article from the Tab newspaper, and a memorandum provided to me by the Community Health Agency of Attleboro, MA, on this issue.

The CHAIRMAN. Without objection, that will be the order.

[Documents and an article submitted by Representative Frank follow:]



## Hospital cost containment affects care of elderly

THE DOVER-SHERBORN  
SUBURBAN PRESS  
FEBRUARY 20, 1986

By RICHARD ROWLAND

Carol Jones is 88 and lives alone. She was admitted to a hospital with a broken collar bone. She also has hypertensive cardiovascular disease, diabetes and osteoarthritis.

When discharged, she was confused and unable to care for herself. She needed a minimum of two weeks on continuous home health care, monitoring of several medications, and help with normal daily routine.

Under the Diagnosis Related Groups (DRGs), Medicare limits her hospital stay but doesn't pay for the continuous care she needs at home.

The DRG system for paying hospital Medicare bills has come to Massachusetts. Here and elsewhere, people see the growing needs of elders for nursing home and home care after leaving the hospital, yet there is no way to pay for it.

The DRG system pays hospitals a predetermined price based on the average stay for the condition treated. At last hospitals have an incentive to deliver only what is needed. Keeping people too long costs them money.

Unfortunately, when Congress set the incentives, it forgot to finish the package. Elders leave hospitals when they can go elsewhere. That's good. But they still need care to recuperate "elsewhere," and Medicare won't pay for very much of it. That's bad.

Many elders need a short nursing home stay or nursing visits in their homes. Congress didn't cover it. Senator Heinz (R-Pa.) held Senate hearings on the problem and Barney Frank (D-Mass.) supports House hearings to find a solution.

Until federal policy changes to cover community care, Governor Michael Dukakis has directed that the Executive Office of Elder Affairs use its state-funded home care services to help.

The elder affairs office is working with hospitals, home health agencies and the state's 17 home care corporations to provide care when elders come home under the new DRG system.

Hospitals can help. A General Accounting Office study found that hospital profits in other states have increased substantially under DRGs. Some of these savings should be invested in the care elders need when they leave a hospital.

Massachusetts hospitals have not had enough time or experience with DRGs to make a commitment, but it's happening in other states. A Kansas hospital uses savings to pay for nursing home and home health care. It can happen here too, and St. Luke's Hospital in New

Bedford is studying the idea.

Hospitals receive payments for 15 days of care for elders who need surgery for a broken hip. If the patient can spend a week or so in a nursing home and there are no complications, he can be discharged in seven or eight days. Since Medicare doesn't cover the type of nursing home care needed, the hospital uses some of the six or seven day's of savings, \$500-\$800 of the \$2200 saved, to pay for the nursing home care and in-home follow-up.

Other conditions may require short-term services at home following discharge.

Hospital financing is more complicated than this example suggests, but the principle holds. Hospitals cannot use all the savings for this care because some patients will stay longer than the average. Some savings, however, can and should be used to provide this care: to send a nurse, a home health aide, a physical therapist, a homemaker or a home-delivered meal to the elder at home.

This investment makes efficient use of hospitals and medical knowledge. Don't treat people in hospitals if they can recover in a nursing home or at home. At present, DRGs can solve half the problem, and it makes the other half worse.

Hospitals are being criticized for premature discharges and a callous attitude toward elders. Unfortunately, a few examples confirm people's stereotypes.

Most hospitals and doctors make sound decisions to discharge people. Now there is a chance to blend compassion, leadership and good medical practice by using savings to pay for post-hospital care.

Hospitals can improve health care without waiting for government to order it. There is too much complaining about government interference and regulation and not enough action. Here is a chance to do something worthwhile without government directives.

The Dukakis Administration urges the federal government to make the right changes before too many elders suffer without care. Until they do, hospitals should demonstrate leadership and strengthen public confidence in their commitment to the people they serve.

Massachusetts hospitals have always been in the forefront on innovation and leadership. We hope they will continue that leadership under the DRG system to help finance post-hospital care.

Richard Rowland is the secretary of the state Executive Office of Elder Affairs.

NEWTON TAB -- APRIL 1, 1986

## Sicker And Quicker

Is Medicare's new  
DRG payment plan  
creating bad  
medicine?

By Chris Calder

Last fall an 82-year-old man left a South Shore hospital after a nine-week stay for congestive heart failure. Four days later, acting on the advice of a visiting nurse who was concerned about his poor condition, the man returned to the hospital, which readmitted him. But less than an hour later, the hospital called the man's wife and told her to come pick him up. Two days later, with a 102-degree temperature and blood pressure of 200/140, the man was taken by ambulance back to the same hospital, readmitted with the same diagnosis of severe congestive heart failure, as well as possible pneumonia in both lungs. After spending another 17 days in the hospital, the man died.

This case was reported to and investigated by the advocacy office of the Massachusetts Department of Public Health (DPH), which found a letter from a hospital administrator to a friend of the patient stating, "recent government programs place severe limitations on what condition can be classified as inpatient (admitted) diagnosis and what can be treated appropriately" outside of the hospital.

The letter referred to changes in the state's hospitals made since last October, when the federal Medicare program — which provides health care for the elderly — started paying Massachusetts hospitals according to patients' diagnoses rather than for actual treatment given. Under the system, ailments of Medicare patients are classified according to one of 468 Diagnostic Related Groups (DRGs) and the hospital is paid an average of what it would cost to treat someone with that diagnosis.

Critics of this new system believe while the old Medicare system may have encouraged too long hospital stays and too many tests, the new system may be forcing some hospitals to emphasize the bottom line at the expense of adequate medical care.

"For all its hoopla," asserts Newton State Representative David Cohen, "DRGs are just an elaborate way of reducing the quality of care to the poor and elderly."

Rob Restuccia, an administrator and director of the House Officers Association at Boston City Hospital, adds that since DRGs have been established, "Most people have felt pressure put on them to discharge people too soon," and adds, "In certain cases, you really want to admit

see DRG, page 26



## DRG

continued from page 1

someone . . . but now you can't do it" because to do so would cost the hospital money.

But Sidney Kaplan, deputy regional administrator of the federal Health Care Financing Administration (HCFA), which oversees the Medicare program, claims a nationwide survey of hospitals found length of stay has on the average dropped only one day per case since the institution of DRGs and admissions have declined only one-and-a-half percent.

### EARLY DISCHARGES

"The feedback from the nursing staff is that patients are being discharged from hospitals much too soon," says Sheila Baum, director of nurses at the 120-bed Newton and Wellesley Nursing Home.

What happens is that a patient is discharged before they are ready and then has to be shipped back to the hospital within a couple of days. This happens very frequently."

Baum says that in the last month, two patients have died in her nursing home "very soon after" being released from a local hospital. She partly attributes the deaths to the DRG system.

Kaplan, however, says, "We don't see any evidence of mortality rates of patients going up" because of the DRG system.

"We haven't found that we're pushing patients out any quicker," adds Brookline Hospital director Raymond Sanzone, who notes a main effect of DRGs has been to prompt more specific diagnoses by doctors outside the hospital. He also says the hospital itself has been paying more attention to efficiency and cost of care for some time.

Barry Spero, president of Newton-Wellesley Hospital, further notes that other than a higher number of surgeries diagnosed as "ambulatory," with patients released the day after surgery or sooner, he knows of no other major changes created by the DRG system.

Spero does say he is unsure if the DRG system really saves money for the health care system, or merely shifts costs from hospitals to home care facilities, nursing homes and the patients themselves. He says he is also leery of DRGs' emphasis on the cost of care. "Using price alone as a judgment (on treatment) can be very disadvantageous to the patient," he says.

### MEDICINE BY REGULATION?

In addition to putting pressure on hospitals to discharge patients as soon as possible, DRG critics maintain the new system's regulations sometimes force hospitals to make questionable medical decisions.

For example, many elderly people enter the hospital with multiple or chronic ailments. Under DRGs, a patient may be treated under only one diagnosis at a time, so that patients sometimes have to be discharged after treatment of one problem, then readmitted for treatment of another, critics point out.

Critics also claim that another DRG regulation says that Medicare will not pay for a patient who is readmitted to the hospital less than seven days after a previous stay, putting pressure on hospitals to either treat the ailments not covered by DRGs and have the hospital pick up the tab, or make the patients wait before being readmitted.

In addition, critics say there is a financial incentive for hospitals to discharge patients as quickly as possible, then readmit them later under the same or a related DRG, thus collecting multiple reimbursements on an ailment that might have been fully treated were the patient allowed to stay long enough the first time. "It's like they're playing checkers" with patients, Baum says.

But Spero insists that at his hospital, "Patients with multiple diagnoses are treated according to their needs."

Some critics also say because there is no allow-

ance in the current DRG system to gauge the severity of a patient's illness, it is more beneficial to the hospital to treat patients who are less sick within their diagnosis category. Cohen further notes that studies have shown that poor people tend to enter the hospital sicker than others, and so are less attractive patients under the DRG system.

"DRGs do not take into account sufficiently the severity of illness," Spero concedes. " . . . But we're not going to turn a patient away because of DRGs."

### LACK OF OVERSIGHT

One problem contributing to fears that DRGs may be causing abuses is that Massachusetts now lacks its usual apparatus to monitor the quality of care in hospitals. The Massachusetts Peer Review Organization (PRO), a board of doctors and administrators, contracted by the HCFA to review hospital health care and which had the power to withhold federal funds from hospitals, folded last summer under criticism that it was not meeting the goals specified in its \$7 million contract. According to Chris Mitchell, health advocate for the state office of elder affairs, another PRO is not likely to be set up for "one to three months."

Currently, complaints about hospital care are being filed with the health advocacy office of the Massachusetts Department of Public Health, but there is no active review of hospitals being conducted. In addition, the U.S. Department of Health and Human Services, which is required by law to produce an annual report about the effects of DRGs on health care quality, has been criticized for being over a year late with its December 1984 report.

Mitchell says the main disadvantage of not having a PRO is that it heightens the fear and confusion regarding the issue. A PRO, he says, would be better at gaining information on possible DRG abuses than at changing the system substantially. But he likened the situation to "a fear of snakes," which the PRO could alleviate by showing "there aren't really that many bites and not all that many people die from them." Also, he says, the PRO could satisfy the federal Medicare review system, which complains that criticism of DRGs is based on anecdotal evidence, by supplying a more systematic account of the system's effects.

## There's Help Available

Since January, the state department of public health's advocacy office has investigated 41 patient and provider complaints about hospital care under the new DRG system. The office, says Philip Johnston, state secretary of human services, is designed "to guarantee quality health care for our elderly."

"In general, the Advocacy Office will seek to resolve complaints by working directly with the hospital, patient and caregiver," Johnston adds. "However, the overriding purpose of the office will be protecting the rights of Medicare patients."

The office can also ask the state's attorney general to file a complaint against a hospital. This power "is a very strong incentive for the facility in question to work cooperatively," notes Mary Breslauer, spokeswoman for the state's executive office of human services.

Reports of suspected cases of discrimination can be made in writing to: Advocacy Office, Division of Health Care Quality, Massachusetts Department of Public Health, 150 Tremont St., Boston MA 02111 or by calling the 24-hour patient protection number at 1-800-462-5540. The office can also be reached Monday through Friday from 9 am to 5 pm at 727-8984.

- A. Kinnane



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### EARLY DISCHARGE SUMMARIES

75 year old woman admitted to Miriam Hospital on 2/13/86. Underwent Coronary Artery Bypass Graft (x4) on 2/25/86. Discharged from home on 3/7/86 with plans for CHA admission on 3/10. On 3/9, patient seen in Emergency Room with pain in left leg, had clots evacuated leaving wound 2" long x 3/4" wide x 1" deep. Send home with instructions for 2 x/day dressings (? why wasn't admitted to hospital then).

CHA admitted patient on 3/10. Patient reports main complaint of constipation, reports had two small BM's since surgery on 2/25 and was sent home from hospital with this problem despite numerous attempts (enemas, stool softeners) to relieve constipation in hospital. Patient also reports telling E.R. staff of severe constipation on 3/9 visit. On 3/10, Visiting Nurse spoke with MD (surgeon) who ordered Colace. On 3/11, VN spoke with MD's office. OK given for fleets, disimpaction, supp. VN attempted with very little success. VN called patient's medical MD who ordered Mag Citrate (1/2 bottle) & repeat in 6 hours. VN called patient two hours later, still very uncomfortable; encouraged her to go to ER rather than wait till evening. Too difficult to manage problem at home.

In E.R., patient given three soap suds enemas, two oil retention enemas with good results but still impacted. (? why wasn't patient admitted). On 3/12, patient feeling better in AM, worse in PM. Patient admitted to Sturdy on 3/10 AM. Patient stayed there for one week. Reports took 5 days to relieve bowel problems.

From Sturdy, patient was admitted to Spaulding Rehab from 3/2-4/2 for extensive cardiac rehab. Patient readmitted to Community Health Agency on 4/2 PM for BID dressing changes. Patient's condition very much improved over admission on 3/10.

Patient definitely sent home too soon after cardiac surgery - with severe constipation problems unresolved. Visiting Nurse questions why she wasn't admitted to hospital on 3/9 or 3/11 when seen in E.R.

43 year old woman (widowed) with rectal carcinoma with question of metastases to liver and lungs. Patient was in Miriam Hospital 2/14-



Supported in part by the United Ways of Northern Bristol County, Plainville and Old Colony.

Early Discharge Summaries

3/18/86 with acidosis secondary diabetes, mellitus, upper GI bleeding, obstructive jaundice. Patient had biliary drainage tube placed 3/4/86. Patient admitted to CNA on 3/19. Patient was sent home from hospital without any plans or discussion regarding care at home. Patient had no one, except one friend (who has own family to care for) to assist her at home. (son in home, but not involved). Patient referral stated "needs assistance with ambulation from bed to chair, feeding self, and commode use. Unable to bathe or dress self." Referral also stated: "Will be home alone during day". Hospital obviously was aware of patient's needs and yet no planning was done - 1) no equipment, i.e. wheelchair or commode were obtained before patient discharged; 2) no arrangements were made for 24 hour supervision patient needed.

CNA attempted to meet these needs on 3/19 and 3/20. Patient was re-admitted to hospital 3/20 PM after two days at home with 24 hour assistance from one friend. Other family members (brothers & sisters refused to be involved - felt patient should have been placed rather than be in home).

Patient was readmitted to Miriam 3/20-25. Was admitted to Woonsocket Health Care Center on 3/25.

Patient should never have been sent home under these circumstances. No plans for 24 hour care at home.

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Two clients terminally ill discharged home secondary status poor but stable; family had very difficult time managing care and hospital unable to accept readmission to hospital. Were not prepared for discharge needs and extent of care needed. Misinformed with promises of care available with home health agency.

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Patient sent home from hospital. When nurse made initial home visit, (next day) found patient experiencing abdominal and rectal pain. Patient had not had a recent bowel movement. Doctor notified. Patient required enema intervention. Patient was extremely upset that he had been sent home in this condition.

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Mr. FRANK. Dr. Desmarais, I must mention the fact that I must tell you you sound remarkably like Congressman Glickman. In case anybody is impersonating your voice, it will be him. And I hope you will not be moved to sing, having heard him on that basis.

I have a couple of questions. As I understand it, there is a 48-hour grace period under this for the patient to stay, and there is also the peer review process. So one would think you could take advantage of that. Except that I am told that the peer review process has a 3-day timetable and the grace process has 2 days, which means that you have 1 day at risk.

Mr. Gejdenson has put some legislation in to make the two together. Would it not make sense to have those be coterminous?

Dr. DESMARAIS. Yes. In fact, that is something we have looked at, and there are various ways you could do it. You could either extend the grace period or you could shorten the amount of time the Peer Review Organizations have to deal with the case.

Mr. FRANK. Or you could split the difference. But you are in favor of making the peer review period and the grace period coterminous?

Dr. DESMARAIS. That is something we have looked at, and it makes a lot of sense.

Mr. FRANK. Doctor, you looked at it, it makes a lot of sense. You are in favor of it. I know a lot of people in here who look at things and I know a lot of things around here make sense. Are you in favor of it or not?

Dr. DESMARAIS. Yes. I believe we are.

Mr. FRANK. Thank you.

There have been questions about the PRO process and how much teeth it has. I am not in general a great believer in peer review. I think peer review is like the House Ethics Committee and the bar association. Usually what happens is after you have been convicted somewhere else, your peers step in and it is like—Murray Kempton said editorial writers do; they come down from the hills after the battle is over and shoot the wounded.

Ordinarily, we are not great——

Self-policing is not even working well at West Point these days, and I do not think it works that great here. So I have concern about that being too much of our reliance. For instance, the recent inspector general's findings found some very serious problems. Only 43 percent of the cases—the Chairman's staff has prepared some statistics here for me which I have found useful. In only 43 percent of the cases with quality problems, all the PRO did was notify you. In 106—133 cases, it says—the Inspector General found the action was not appropriate.

Are they working well, the PRO's?

Dr. DESMARAIS. Yes, they are. They are working better. We have worked very closely with the inspector general and his staff on this issue, as is reflected in his final report. We have made a lot of changes, and much of the study that was done by the Inspector General was done very early on. In fact, many of the cases pre-date Peer Review Organizations entirely. So I do not think one can look to that early experience and say that that is what is occurring today because we have changed things quite dramatically.

Mr. FRANK. This is my last question.



Congressman Stark has worked hard on this, and I have to say I understand your conclusion, that you do not find a systemic pattern. This reminds me in some ways of disability, and people sometimes ask us what is the connection between the case work that your staff does and your legislative work. Sometimes the connection is that if they do the case work good enough, we can stay here to do the legislative work. But sometimes the case work becomes information on which we decide. That was clearly the case in disability. This Congress enacted legislation dealing with disability because in almost every member's district across the country we were hearing horror stories about mistreatment, and the DRG's are now taking that situation.

It is true it is anecdotal, but you have a couple hundred of us getting anecdotal evidence. I am persuaded by that as in the case of the disability.

You know, we do not invent these things. The DRG's are a fairly abstruse issue. The complaints you are getting are entirely constituent-driven. We are sitting here and we are hearing about this older person, that older person, and this relative and that relative who were damaged.

One of the things that Congressman Stark has proposed is that we enact some legislation that would have some penalties for people who act to throw people out early. Now, I thought criminal penalties were inappropriate because of the nature of this. But the Judiciary Committee and the Ways and Means Committee have proposed some legislation and voted for it, that would have some civil penalties against hospitals and doctors who use this and throw people out too early. What is your general attitude on those kinds of issues?

Dr. DESMARAIS. We have got additional authority today to impose penalties for premature discharge. We deny payment and we throw them out of the program. We are certainly in favor of a program to do that.

Mr. FRANK. We are talking about beyond that. For some cases, unfortunately, being thrown out of the Medicare program is like being thrown into the briar patch. So what about fines?

Dr. DESMARAIS. We use financial penalties. The Inspector General uses them now in some instances of premature discharge.

Mr. FRANK. So it would be appropriate to do it. Thank you.

Dr. DESMARAIS. We have supported the additional authority that has been granted to us recently.

Mr. FRANK. My time has expired. Thank you.

The CHAIRMAN. The Chair recognizes Mr. Spence.

Mr. SPENCE. I have no questions, Mr. Chairman.

The CHAIRMAN. Mr. Synar?

Mr. SYNAR. Thank you, Mr. Chairman.

Doctor, let me read you three statements out of your prepared testimony and remember each one of them.

You say on page 3, "Beneficiaries are receiving care in more appropriate settings in an outpatient department and a skilled nursing facility, or home arrangements and home health care agency."

On page 6, you say, "The number of Medicare-only certified SNF's increased from 276 to 495, and the number of duly certified



Medicare and Medicaid SNF's rose from 5,233 to 6,243 during the same period."

And then on page 7, you say, "Hospitals earned a higher average profit in Medicare payments during the first year of PPS."

Now, take those three statements, if you would, and tell me whether or not you broke those down between urban and rural, and whether those statements are true if you take it strictly in the rural setting.

Dr. DESMARAIS. We certainly could break them down. I do not have those numbers with me now. But, certainly, there are more facilities in an urban setting than there are in rural settings.

Mr. SYNAR. So there is a chance that we have less skilled nursing homes in rural areas than before the enactment of PPS. Right?

Dr. DESMARAIS. I would find it hard to believe we have less; that the total number has fallen. We can certainly submit those numbers, broken out in that particular fashion.

Mr. SYNAR. With respect to the statement on page 6, you would say there is probably more health care available in the rural areas than there was?

Dr. DESMARAIS. Certainly.

Mr. SYNAR. Then on page 7, you would say that hospitals have earned a higher average profit?

Dr. DESMARAIS. This is based on work the Inspector General did, looking at a sample of 892 hospitals, which I understand they have expanded now to several thousand. They are finding in the first year of prospective payment that the cost of caring for Medicare patients, compared to what we paid them, has resulted in a higher profit margin on average for the hospitals that they examined.

Mr. SYNAR. Well, let me suggest that on page 7 when you say hospitals are earning a higher profit from Medicare payments during the first year of PPS, that that is not the case. Our Task Force on Rural Elderly found that the fact that rural hospitals are having to care for more and more Medicare patients, because that is where the elderly are living now in the rural areas, up just 27 percent in the last couple of years.

What I would appreciate, and I would ask the Chairman, if he would, is to have these figures you have presented today, if you could present us a supplemental breakdown between urban and rural so that we could get a better understanding of these numbers as they relate to rural areas.

Dr. DESMARAIS. We would be happy to do that.

Mr. SYNAR. Thank you very much.

The CHAIRMAN. That will be accepted for the record, and it will be printed at this point.

[The following material was subsequently received from Dr. Desmarais:]

Our records show as of May 1, 1986 that of the 5,993 HHAs certified, 2,472 are located in rural areas and 3,521 are in urban areas. The current number of Medicare only SNFs is 465, of which 83 are in rural areas and 382 in urban areas. Of the 6,351 SNFs that are dually certified for Medicare and Medicaid, 1,797 are in rural areas and 4,554 are in urban areas.

Regarding hospital profit under PPS, the Inspector General's report shows that net profit for the first year of PPS was 15.6 percent for urban hospitals and 7.79 percent for rural. Of the rural hospitals studied, 67 percent realized a profit under Medicare versus 89 percent for urban hospitals. It should be noted, that the IG

study found strong correlation between profitability and Medicare revenue, i.e., the greater the Medicare revenue, the better the hospital's chance of making a profit.

The Prospective Payment Assessment Commission (ProPAC), in its April 1986 report, also found that rural hospital profitability—as measured by hospital operating margin ratios in 1984—had increased significantly.

The CHAIRMAN. The Chair now recognizes Mrs. Bentley.

Mrs. BENTLEY. Thank you, Mr. Chairman.

Dr. Desmarais, how do you determine how many days a patient should be in a hospital for an illness?

Dr. DESMARAIS. We do not determine how many days they should be in the hospital.

Mrs. BENTLEY. Well, who sets the rule?

Dr. DESMARAIS. We do not set any such rules. We have average lengths of stay. They are billed off of all the Medicare cases. We looked at nearly 11 million Medicare cases and determined and calculated average lengths of stay for every one of the 470 DRG's. But those are average lengths of stay. If an average for a particular case or type of case is ten days, you may stay as long as is medically needed. There is nothing that says in any Medicare rule that you are to be discharged when the average length of stay is reached.

Mrs. BENTLEY. Then I think you better explain that to the hospitals because the hospitals out there are not aware of that.

Dr. DESMARAIS. Well, they should—

Mrs. BENTLEY. They have—and I want to tell you because I have been around hospitals a great deal recently. I have not lost myself here in the walls of Washington, and I have been out there. But I know what the hospitals are telling the patients, and I know how fast they are getting them out. They are saying 5 days for this, or 5 days for that; 8 days for that, and out. And I have had too many of my constituents come to me and tell me this.

I have a case here of a woman who could not walk, and they sent her home because her 5 days were up. And her doctor did not want to send her home either. But she was sent home because that was the time for that illness.

Now, somewhere along the line I think you had better explain to the hospitals just what you mean so that they understand it. I am very disturbed. You just talk through your testimony as if nothing is happening out there to adversely affect the patients. And I can tell you that it is.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mrs. Bentley.

Mr. Vento.

Mr. VENTO. Thank you, Mr. Chairman.

I think that Mrs. Bentley reflects really what we are hearing, and we all understand the purpose of the law. But I do not think in the real world that that is what is occurring. Literally every meeting that we go to, all of our caseworkers, there is a great deal of confusion about this. I think the real problem, Doctor, is that unless there is an advocate to represent patients, a real advocacy program, you are not going to solve this.

Let me ask you a question. When patients are—Medicare patients are brought to a hospital setting, prior to receiving service or at the instance of receiving service, do they receive notification of

their rights with regard to how they would go about exercising this right if they are going to appeal an early discharge, a premature discharge?

Dr. DESMARAIS. Yes, sir. They are handed, "An Important Message From Medicare," which on one page outlines what Peer Review Organizations are all about; it outlines the appeal rights the patients have. It is in fairly simple language. We consulted very widely with representatives of the beneficiary community, members of this committee's staff, and other—

Mr. VENTO. When was that initiated, Doctor?

Dr. DESMARAIS. This was initiated several months ago.

What we had earlier was a requirement that such information be made available. Because of a lot of concerns and complaints, we decided to provide standard language in simple English that would succinctly summarize those kinds of information.

Mr. VENTO. I think you—it does not look like it is printed—it looks like pretty small print from here. I have not seen it. And I suppose there might be a copy of that already included in the record. If not, Mr. Chairman, I would ask unanimous consent that it be submitted for the record.

The CHAIRMAN. Without objection, it will be ordered.

[Medicare message to patients follows:]

AN IMPORTANT MESSAGE FROM MEDICARE**YOUR RIGHTS WHILE A MEDICARE HOSPITAL PATIENT**

- \* You have a right to receive all of the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. Your discharge date should be determined solely by your medical needs, not by "DRGs" or by Medicare payments.
- \* You have the right to be fully informed about decisions affecting your Medicare coverage or payment for your hospital stay.
- \* You have a right to appeal any written notices you receive from the hospital or Medicare stating that Medicare will no longer pay for your care.

**TALK TO YOUR DOCTOR**

You and your doctor know more about your condition and your health care needs than anyone else. If you have questions about your medical treatment, your need for continued hospital care, or your discharge date, consult your doctor. These decisions should be made between you and your doctor. If you have questions or concerns about hospital services, you should talk to the hospital's patient representative or discharge planner. Don't hesitate to ask questions—you and your family should ask about your care, your stay in the hospital, and your planned discharge.

**PEER REVIEW ORGANIZATIONS**

Peer Review Organizations (PROs) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. Peer Review Organizations will respond to your request for review and appeal of written notices stating that Medicare will no longer pay for your hospital stay.

**IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON**

- \* Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. The hospital's written notice is necessary if you decide to appeal to the PRO. The written notice must describe how you appeal.
- \* If you decide to appeal, do so immediately—either call or write the PRO. If you lose the appeal, you may be billed for all costs of stay beginning with the 3rd day after you receive the written notice. The appeals process can take up to three working days from the time your appeal request is received. Thus, if you appeal and lose, you may have to pay for at least one day of hospital cost.
- \* **REMEMBER: WITHOUT A WRITTEN NOTICE, YOU HAVE NO RIGHT TO APPEAL.**

The Peer Review Organization for this area is:

TELEPHONE: (     )



Mr. VENTO. Thank you, Mr. Chairman.

Who exercises this particular option, only the patient, or can someone else that is concerned with the patient exercising that option?

Dr. DESMARAI. A member of the patient's family could also exercise those appeal rights.

Mr. VENTO. And in the absence of a member of a patient's family, or—

Dr. DESMARAI. Whoever is legally responsible for the patient.

Mr. VENTO. The concern, of course, is that then this appeal process kicks in, but what happens to the patient during the appeal process?

Dr. DESMARAI. The patient could stay right where they are and not leave the hospital.

Mr. VENTO. The way it is being administered, of course, that is not the impression that patients are receiving in the institutions or the hospitals where they are staying.

You point out the increase in intermediate health or nursing care facilities, that—intensive care facilities. What is—is that covered under Medicare, these particular facilities; are they covered under the Medicare program?

Dr. DESMARAI. Skilled nursing care is covered under the Medicare program.

Mr. VENTO. And the incidence of that is that the medical doctor has to—in other words—certify that patient for that type of care, is that correct?

Dr. DESMARAI. Yes, you need to require that level of care.

Mr. VENTO. There seems to be rising incidence—you seem to be very proud of the fact that there is a lot of what we call hospital-day surgery, or outpatient surgery.

What is the difference in terms of a payment system for a hospital-day type of surgical process and one that requires in-hospital surgery?

Dr. DESMARAI. There is not a simple answer to that question. It depends on the kind of facility the surgery is done in. If it is done in a free-standing ambulatory surgical center, we have essentially a prospective payment system in that setting. If it is done in a hospital outpatient department, that is generally reimbursed on a cost-based system in the old way.

Mr. VENTO. But the hospital-day surgery and the former example that you are giving is becoming increasingly the practice that is followed, is it not; the hospital-day surgery, in which it is reimbursed from the prospective payment system?

Dr. DESMARAI. There is a lot more outpatient surgery being done today. Reimbursement for outpatient surgery is an area that we are looking at to try to reform the way we make payment. In fact, there are several members of Congress interested, not the least of whom is Senator Durenberger. And there have been hearings to suggest that we ought to have a more level playing field, no matter where the surgery is performed.

Mr. VENTO. You also point out the concerns with regard to the fact that there are a lot of different group health programs, the HMOs that are now covering a variety of services. But the fact of the matter is that if someone is not in one of those programs, they



have a big gap in terms of coverage. As an example, only one or two percent of the entire nursing care costs would be covered under the normal Medicare program.

Dr. DESMARAIS. That is correct. The Medicare Program, as an acute care program, only covers some nursing home care. Much of it is covered by the Medicaid Program because much of it is custodial care in intermediate care facilities. Of course, we as an administration are doing everything we can to move toward capitation and to encourage the growth in the number of health maintenance organizations and competitive medical plans.

Mr. VENTO. Well, the problem is that that does not—the traditional way of acquiring assurance in this Nation is simply not—the percentage covered by such type of more comprehensive plans, that someone may or may not have the prudence to purchase ahead of time, especially among the elderly, is still not that high in terms of numbers. Most of them are dependent on the nontype of comprehensive or HMO type of plans. So they obviously fall between the cracks in this instance.

Dr. DESMARAIS. That is true. I would observe, however, that even health maintenance organizations do not necessarily cover custodial care in nursing homes. That is not necessarily part of their benefit package. After all, they are paid 95 percent of what we would expect to pay in the traditional fee-for-service system under Medicare. And given that we do not cover custodial care, certainly none of those costs are built into what we pay HMO's.

The CHAIRMAN. The time of the gentleman has expired.

Mr. VENTO. Thank you.

The CHAIRMAN. Mr. Fawell.

Mr. FAWELL. Perhaps these are more observations, Doctor, than questions. But it seems to me that you are sort of on the spot. You are darned if you do, and darned if you don't, in a sense.

Before PPS, we heard a lot of criticisms of hospitals about keeping patients too long and building up costs, excess beds, and things of this sort, and certainly a lot of alleged malpractice. And now it is the opposite, that it is sooner and quicker, et cetera.

I cannot help but believe that there must be an awful lot of honest hospital services out there who, under either system, are giving quality health care.

It has been mentioned that there are some 2,000 cases of premature discharges since PPS came into being. Are there more premature or "sooner and sicker" discharges now than before? Has anybody made the comparisons?

Dr. DESMARAIS. Well, interestingly enough, no one watched for those kinds of quality concerns prior to prospective payment. However, we do have underway a variety of studies that will attempt to make those kinds of pre- and post-prospective payment comparisons to try to get at the very question you raise.

Mr. FAWELL. I assume that there must have always been, I suppose, hospitals that may discharge too soon. The implication is, if there is money to be had in the Federal Government, you don't have to worry about that. The hospitals will keep patients a real long time if, by keeping them for a long time, you are going to lose money, then they are out sooner than should be.

The issue that we are looking at is the question of quality of care. And when you have longer term hospital care, you also, as you have pointed out, have the incentive, to keep patients longer than necessary. With the shorter term hospital care, however, we have more of the nonhospital services and community health service programs that we did not have before.

In the longer term hospital care, which was in existence under PPS, you do not have as many of these. So is it not a bit early to judge overall health care services. If you look at the total question of quality of care, you have to look at both of those aspects, do you not?

Dr. DESMARAIS. You have to look at a variety of things, and you have to continue to look. We cannot just assume that because everything is in relatively good shape today that that will continue. That is why we continue to work with the Peer Review Organizations. That is why we are revising the scope of work, to expand the kinds of quality monitoring that they do. That is why we have a super-PRO to check on and see how well the Peer Review Organizations are working. I think we are trying to do whatever we can to assure that quality is maintained.

And we are convinced that quality and cost-effectiveness can and will go hand in hand.

Mr. FAWELL. I certainly do not envy you in trying to perform the task of making that difficult subjective determination of quality of care, with all of the variables that might be involved. It certainly is very interesting to get the figures as they come out.

It seems to me there has been quite a lot of what might be called more adversarial critical judgments, and perhaps they are quite right. But, on the other hand, it seems to me that with the incentives to have quality home service care and also the competitive revolutionary features of the delivery of health care services in general that this could bring, in the long term if not short term, some distinctly higher quality of care that we did not have before.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Schuette.

Mr. SCHUETTE. Thank you, Mr. Chairman.

Doctor, thank you for being here today.

If the chairman has no objection, I will have a statement for the record that, in the interest of time, I will submit.

The CHAIRMAN. Without objection, that will be the order.

[The prepared statement of Representative Schuette follows:]

## PREPARED STATEMENT OF REPRESENTATIVE BILL SCHUETTE

MR. CHAIRMAN, MY FELLOW COMMITTEE MEMBERS, HONORED WITNESSES AND GUESTS, I AM PLEASED TO HAVE THIS OPPORTUNITY TO SPEAK ON THE CRISIS OUR SENIOR CITIZENS FACE IN OBTAINING ADEQUATE QUALITY HEALTH CARE.

IN THE 10TH CONGRESSIONAL DISTRICT OF MICHIGAN, WHICH I REPRESENT, SENIORS AND HOSPITAL ADMINISTRATORS ALIKE HAVE EXPRESSED THEIR CONCERNS OVER ACCESS TO QUALITY HEALTH CARE UNDER THE CONSTRAINTS OF MEDICARE COST CONTAINMENT. WITH THE IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM IN 1983, MANY CHANGES AFFECTING PATIENTS, HOSPITALS, DOCTORS, AND OTHER HEALTH CARE PROVIDERS HAVE TAKEN PLACE, AND THOSE PARTICULARLY HIT THE HARDEST ARE THE RURAL ELDERLY. MY GREATEST CONCERN IS FOR THE ELDERLY IN MY RURAL DISTRICT WHO NEED HEALTH CARE SERVICES, RANGING FROM EMERGENCY TREATMENT TO LONG-TERM CARE. IT IS THESE SENIORS WHO SUFFER UNDER THE PRESENT SYSTEM WHEN HOSPITALS ARE FORCED TO CUT COSTS UNDER MEDICARE PPS AND MUST DISCHARGE ELDERLY PATIENTS EARLIER THAN IN THE PAST. OFTEN THE HOSPITALS IN MY DISTRICT ARE THE ONLY SOURCE FOR HEALTH CARE TO THESE RURAL ELDERLY. I DO AGREE THAT WE NEED A FISCALLY SOUND HEALTH CARE SYSTEM, AND MEDICARE PROSPECTIVE PAYMENT HAS INSTITUTED VAST SAVINGS. ON THE OTHER HAND, THERE ARE PROBLEMS WITH THE SYSTEM AND IT IS THE ELDERLY THAT PAY THE PRICE FOR THE SYSTEM'S INEQUITIES. WE SHOULD REDUCE COSTS WITHOUT SACRIFICING AMERICA'S RURAL EDLERLY.

I HAVE MET WITH SEVERAL HOSPITAL ADMINISTRATORS OF RURAL HOSPITALS IN MID-MICHIGAN. THEY ARE TRULY CONCERNED ABOUT HOW THE

TIGHTENING OF MEDICARE POLICIES ARE AFFECTING THE QUALITY OF CARE WHICH PHYSICIANS PROVIDE. WITH PRESSURES TO CUT COSTS, SOME ELDERLY ARE DENIED HOSPITAL ADMITTANCE OR DISCHARGED EARLIER, WITHOUT THE NECESSARY CARE THEY NEED. IT IS OUR DUTY AS MEMBERS OF CONGRESS TO ASSURE THAT THE MEDICARE COST CONTAINMENT POLICIES DO NOT ROB THE ELDERLY OF QUALITY HEALTH CARE IN EXCHANGE FOR FISCAL RESPONSIBILITY. COST CONTAINMENT CANNOT TAKE PRECEDENCE OVER QUALITY OF CARE.

TODAY WE WILL DISCUSS THE PROBLEM OF EARLY DISCHARGES WHICH HAVE OCCURRED SINCE THE INCEPTION OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM. AT THIS TIME LAST YEAR, THIS COMMITTEE HELD A HEARING ON COST CONTAINMENT IN CONJUNCTION WITH THE TASK FORCE ON RURAL ELDERLY. WE HEARD TESTIMONY FROM MEDICARE BENEFICIARIES, HEALTH CARE PROVIDERS AND MARTIN KAPPERT FROM HEALTH CARE FINANCING. UNFORTUNATELY, THE CRISIS HAS GROWN SINCE LAST YEAR. WITH SENIORS FACING INCREASED OUT-OF-POCKET HEALTH CARE COSTS, AND HOSPITALS FACING SHRINKING RESOURCES DUE TO MEDICARE BUDGET REDUCTIONS, WE MUST SERIOUSLY CONSIDER HOW TO IMPROVE THE MEDICARE SYSTEM.

I AM PARTICULARLY ANXIOUS TO HEAR COMMENTS FROM THE ACTING ADMINISTRATOR OF HCFA, DR. DESMARAIS, ON HOW WE MAY ACT TOGETHER TO RESOLVE THE SYSTEM'S PROBLEMS. THANK YOU MR. CHARIMAN.



Mr. SCHUETTE. I have one question for the doctor.

I represent a rural district in Michigan. And the concerns and health concerns of the elderly is of prime importance to me. And, obviously, this whole question of health care today is trying to balance and reach two competing goals, twin goals of quality health care at a reasonable cost. And those are two goals we strive for. However, as important as those two goals are, the whole question of early discharge puts in jeopardy the question in issue of quality health care for people.

I have reviewed your statement, Doctor, and you have stated on page 4 that there is a continuing concern of beneficiaries being discharged prematurely, and you go through later in your statement about some of your comments. And this—if this has been asked before, I apologize. But what is the administration's viewpoint and your viewpoint, sir, within HHS in terms of steps and remedies and suggestions and avenues that you suggest to be taken. Obviously, Congress will look at this clearly as well. But how would you say that we should try to deal with this question of premature discharge for those who are in desperate need of quality health care, sir? What self-internal, self-help, and corrective measures can be taken that protect the elderly and all patients who are infirm in a hospital?

Dr. DESMARAIS. Well, I think one very important thing is to continue to educate not only our senior citizens, but also providers and physicians about their roles, their responsibilities, what this new system is all about, what it is not all about; try to dispel some of the myths and misunderstandings. After all, it is a revolutionary system. It is very different than the days of cost-based reimbursement when no one really worried about the issue of cost-effectiveness and efficiency.

So I think anything we can do, working together in educating individuals is important. In addition to that, of course we have to monitor what is going on. And there are two ways to do that. The first way is on a day-to-day basis through the Peer Review Organizations, and I have said a lot about that. The second way is in a more global research kind of way, of checking the statistics, reviewing medical records, and aggregating that data to see if there are any trends, unexpected trends or trends that are discouraging that would require some changes in the way the system is working.

I think, finally, and something we are actively at work on, is refinements in this prospective payment system so that it is even better, that it pays appropriately, that it accounts for severity of illness better than it does today, and so on. And I think all of those things need to continue to be done.

Mr. SCHUETTE. Doctor, what type of comments are expressed to you in your capacity? Do you hear from doctors and hospital administrators on some of their concerns? And how do they reach you; is this letter, phone call, what have you?

Dr. DESMARAIS. A variety of ways, including, of course, advocates such as yourself, who invite us in to meet with constituents. And we do a lot of that. We receive lots of mail, and so do our contractors, whether it is the Peer Review Organizations or the contractors who pay claims. There are toll-free hotlines available to beneficiaries. Of course, many of them use their own advocacy groups,



like the American Association of Retired Persons, and others, to speak on their behalf.

Mr. SCHUETTE. How often—do you go out to the field, so to speak, and hear directly from a doctor or a patient?

Dr. DESMARAIS. As often as possible. I have spent whole days, recently spent the entire day with the Montana Hospital Association, most of whose members are rural hospitals; sitting at a roundtable discussion and hearing from each one of them. I was recently in New Jersey for a very good forum put on by the New Jersey Hospital Association to establish a better dialog between the beneficiary community in New Jersey and the hospital and physician communities. And we were very much a part of that particular activity.

Mr. SCHUETTE. Have you been to Michigan yet?

Dr. DESMARAIS. I have not personally been—

Mr. SCHUETTE. Would you like to come?

Dr. DESMARAIS. I would be delighted to consider an invitation.

Mr. SCHUETTE. Well, sir, an invitation may well be issued. Thank you very much.

Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Thank you very much.

Doctor, I see from your testimony that you describe the PROs as a strong, medical review mechanism. But the inspector general seems to disagree in his findings. It is indicated that in 43 percent of the cases with quality problems that the only action which the PROs took was to notify HCFA. He examined 133 cases. Of those 133 cases that were subjected to review, he found that PROs took no appropriate action in 106 cases. That's a very high percentage.

He also found that 30 percent of the PROs were not even reporting cases of premature discharge and inappropriate transfers. A clear indication that he does not agree that PROs are a strong medical review mechanism.

However, you also took the position in your testimony, and you said that the first 2 years' experience revealed the need to refine PRO efforts in the area of quality care. Well, I agree. I think that is fine. Now, what we want to know is, what specifically in HCFA's 2 years experience led you to conclude that some changes regarding PROs are necessary, and what are the changes?

Dr. DESMARAIS. Well, the kind of dialogue we have had here, the dialogue we have had with beneficiaries, providers, and the Peer Review Organizations themselves, all of that experience caused us to improve. And, in fact, we have used the inspector general's report, and his report dealt with the very early period of the Peer Review Organization, to make refinements. Some of them include providing clearer authority to Peer Review Organizations in instances of premature discharge, and what they should do about those. We have revised the scope of work to focus the reviews better and to include quality of care screens, the quality screens that I mentioned.

If you find a case in which the patient has had trauma in the hospital, had a hospital-acquired infection, returned to the operating room unexpectedly, died in the hospital, was not medically stable at the point of discharge, no discharge planning was done; any one of those incidents will subject that entire case to very intense review of the medical record to determine if the incident

could have been avoided or if it could not have been avoided, no matter how hard anyone tried. If there is a confirmed quality of care problem, to move more aggressively to deal with it.

As I pointed out earlier, we also have the super-PRO reviewing what the PROs are doing. And we also have our regional offices doing that on a day-to-day basis.

So we have learned from lots of people who have given us advice. We have made changes, and we intend to continue to make appropriate changes.

The CHAIRMAN. Thank you, Doctor.

I have a list of other questions that I would like to submit to you so that you can answer them in writing. But I must ask this one question.

I was pleased to see that the Reconciliation Bill, which is H.R. 3128, was signed by the President this week. Now, this bill blocks the administration from dropping the Medicare waiver of liability. What alternatives to the waiver, such as reviewing claims up front, are you now considering?

Dr. DESMARAIS. Well, we certainly are going to look at that issue. I think we want to guard against instituting anything that will increase our administrative costs. They are already quite high. We do not want to submit every claim to pre-admission or pre-procedure review.

The Peer Review Organizations do do some review, ahead of admission or before the procedure. A lot of our review is done, as you have pointed out, after the fact. It is a retrospective kind of review. We will certainly continue to consider what we might do. We felt we had good reasons for removing the waiver of liability. Congress disagreed. And the law being the law, we certainly implemented it. And, in fact, although the regulation would have allowed us to end waiver of liability for nursing home and home health on March 24th, we did not implement that because we fully expected the President would sign Reconciliation. And so we acted in a very prudent fashion.

The CHAIRMAN. Thank you, Doctor.

Is there any member of the committee who has any additional questions?

Mr. Vento?

Mr. VENTO. Mr. Chairman, I just want to point out that I just read this important message from Medicare to the patients. It is obvious to me, just for the record, that this, first of all, is a—I think a process where you are saying that you have to receive written notice from the hospital.

Doctor, do you know what are the instances of written notice given to the entire patient group? It is not common to get written notice about discharges unless you are actually in a protest situation, is it?

Dr. DESMARAIS. It is not common simply because the physician is the one who, as the patient's advocate, makes the decision in most instances about whether or not the patient is ready for discharge. What we are talking about here is instances when it is the hospital who says, "We don't care what the physician believes. We think the patient ought to be discharged." Those instances and some similar ones, where written notifications are actually issued.

Mr. VENTO. But why do you require written notification for an appeal situation? What is the purpose of that?

Dr. DESMARAIS. The instances where we require written notification are the instances where the possibility exists that the patient might be disadvantaged; that in fact it is the hospital, out of its own financial interests, which is deciding to discharge the patient against the wishes of not only the patient, but against the wishes of the physician.

Mr. VENTO. In other words, the assumption is here that if the medical doctor discharges that that is—that written notice is not provided to the patient under those circumstances, that that is appropriate, an appropriate discharge?

Dr. DESMARAIS. That is correct. And the physician certainly signs those discharge orders.

Mr. VENTO. The other point I just want to make clear. I don't necessarily agree with that. I think that sometimes physicians are under a lot of pressure in terms of review and would—may appear to be, especially if they are treating certain patients that have problems, where they may indeed need additional care, they may appear to be out of the norm and obviously don't want to rock the boat. So I think what you have to depend upon is the physician that is going to sail against the wind, so to speak, in terms of this particular issue. The fact of the matter is that we also have the medical doctors—and I know that they are prepared to testify today—talking about the severity of illness as being a factor; something which is not addressed in the prospective payment system today.

Dr. DESMARAIS. Well, it is addressed, but indirectly. The indirect medical education adjustment that is provided in the teaching hospitals all across the country—

Mr. VENTO. Listen, when I first read the DRG bill, prospective payment system, I thought we were going to have more exceptions than you could shake a stick at. The fact of the matter is that there have been very few exceptions. You have been very tough on that. And I think you have to be somewhat tough if the system is going to work, but that is not really addressed in the context—realistically, I mean. You can count on your two hands the number of exceptions that you have made in terms of that, don't you think so, Doctor?

Dr. DESMARAIS. No, sir. Every case, Medicare case in every teaching hospital in this country—there are several thousand of them—each one of those receives an additional payment under the prospective payment system.

Mr. VENTO. So your advice is that if you have severity of illness, condition, make sure you head for the right hospital or you're in big trouble.

Dr. DESMARAIS. Well, that's the law. And the law—

Mr. VENTO. I know. But I think it is sort of a mismatch, and I am glad you are reflecting the problem with that. And I hope that you would reflect that problem in your response.

Dr. DESMARAIS. Yes. In fact, severity of illness is one of the things we are interested in attempting to resolve; finding an appropriate way to distinguish between patients in the same DRG with respect to severity and make appropriate payment.



Mr. VENTO. Well, the other point that I—point to the committee members is that there is a provision in here that if you do appeal, if you get this written notice and you decide to appeal, you are supposed to talk to the discharge planner. Well, the discharge planner, I assume, is the guy who is working at the hospital, or the woman, that is in charge of making sure that they keep patients moving along; isn't it? I mean, you have to listen to a sales pitch from the discharge planner before you can—in other words, as to recommending that they do, or recommend you talk again to the physician, just so everyone is alerted here.

Dr. DESMARAIS. Well, they are a common source of information to patients.

I observed, in this very highly competitive environment that we have, if any hospital in this country thinks that it cannot take care of patients from the time of admission to the time of discharge and assure their continued needs are met after discharge, that hospital will quickly acquire a very bad reputation. And in a very competitive environment, that is not going to last very long.

Mr. VENTO. One other point is that there is a monetary penalty in here for a third day of care if you—if a decision has not been made at that point, you may be liable to that. And I would just point out that I do not know what the cost per day is on the average. But in Minneapolis-St. Paul, where I hail from, it is anywhere from \$600 to \$900 a day in cost, which I am sure is a significant deterrent when you put that type of provision in there. And I think that really is—I think these impediments to it, and I realize we don't want spurious types of claims for this, just for a place to rest.

One more question, Mr. Chairman.

The last factor, what is the percentage of appeals that we are getting on a 1,000-patient basis? What are the—per thousand, how many appeals do we have under the prospective payment system?

Dr. DESMARAIS. I'm sorry, but we will have to submit those numbers for the record.

Mr. VENTO. Well, I think it is very important, Mr. Chairman, to see whether or not this process is—any workability whatsoever. And I hope that they would submit that, and I will be looking for that in the record.

Thank you, Mr. Chairman.

[The following material was subsequently received from Dr. Desmarais:]

We do not maintain data on the number of appeals per patient nor by PPS and non-PPS facilities. In terms of actual request for Part A reconsiderations, our data base was not accurately maintained until FY 84, the first year of PPS. However, current data indicate that less than 0.2 percent of Part A claims processed are appealed and less than 1 percent of inpatient hospital denials are appealed. This would seem to suggest that appeals could not have changed substantially since the advent of PPS.

The CHAIRMAN. Thank you very much.

Ladies and gentleman, I would like to ask some more questions of the doctor, and then go on with the hearing. However, I think the best thing to do, Doctor, is to submit these questions in writing to you, and you can respond to them at your leisure. I hope that can be done as soon as possible.

On behalf of the committee, I would like to thank you for your testimony this afternoon.

[Written questions were subsequently submitted to Dr. Desmarais by Chairman Roybal. Answers to those questions had not yet been received at the time this publication went to press.]

Dr. DESMARAIS. Thank you, Mr. Chairman.

The CHAIRMAN. It is our pleasure today to have with us our colleague, Hon. Martin Frost, who is the chairman of the Health Task Force of the House Budget Committee.

He has asked to appear before us today and give us the benefit of his perspective. In just a few days, Mr. Frost and the Budget Committee are going to be making some very tough decisions which might affect Medicare beneficiaries and their providers. Ladies and gentlemen, it is for this specific reason that we would like to have him testify at this time.

Mr. Frost, will you please come forward and proceed in any manner that you may desire.

**STATEMENT OF HON. MARTIN FROST, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS; AND CHAIRMAN, HEALTH TASK FORCE OF THE HOUSE BUDGET COMMITTEE**

Mr. FROST. Mr. Chairman and members of the committee, thank you for inviting me here today to talk about a subject that is of great personal concern to me. I am pleased that the committee has chosen to investigate the potentially very serious problem of premature discharge of Medicare patients. I am eager to be helpful in any way I can.

When we initiated the prospective payment system in 1983, its sole purpose was to halt skyrocketing health care costs by encouraging hospitals to provide services in a more cost-efficient manner. It appears that our efforts are succeeding, and we are getting hospital costs under control.

It has become increasingly obvious, however, that some mid-course corrections may be needed to ensure that the quality and availability of services to our senior citizens are not eroded.

As chairman of the Budget Committee's Task Force on Health, I have heard testimony from both health care providers and consumers regarding the problems they have had with the prospective payment system. Most alarming has been the contention that some elderly patients are being released from the hospital before they are medically ready.

There is no doubt that PPS has reduced the length of hospital stays for Medicare recipients. Prior to PPS, the average length of stay was 9.5 days. Patients being admitted last year under the new system spent an average of 7.5 days in the hospital, a reduction of 2 days or 21 percent. The very serious question now confronting us is this: does this reduction in the length of stay represent a cut in the fat of hospital services, or have we cut past the fat into the flesh and bones of needed medical care?

The Reagan administration has continually maintained that there is no solid data to document claims that the quality of health care for the elderly has declined. It is true that up to this point our fears have largely been based on letters from elderly constituents



or news reports of seemingly isolated incidents. Now, however, hard evidence has begun to mount, and much of it is disturbing. Last year, a 4-month staff evaluation by the Senate Aging Committee concluded that, "some seriously ill Medicare patients are being inappropriately and prematurely discharged from the hospitals." One national study to look at the effects of the DRG system is being conducted by the University of Texas Health Science Center at Dallas. It is just in its earliest stages and has only preliminary findings comparing individuals hospitalized prior to and after DRG's in Texas. But those early findings do reinforce our concern. Hospital readmission rates increased substantially. These individuals were often readmitted to different hospitals, yet 60 percent of them were readmitted for the same problem.

Most troubling is the fact that, although Medicare patients are being released in greater need of post-hospital care than ever, the appropriate post-discharge care is not consistently accessible or available. Families are forced to assume an increasingly large financial and care-giving burden, and the patient often finds himself hospitalized again. Most hospitals have responded responsibly and are now devoting more effort to planning a patient's discharge. Neither the families nor the hospitals, however, have received the assistance they need from the Federal Government. In spite of the obvious growing importance of post-hospital care, the Reagan administration has chosen a course of action that would drastically reduce access to these essential services. Clearly, it is time for us to reexamine the Medicare Program.

A greater number of patients are being released quicker and sicker to home health agencies, but Medicare has not expanded its commitment to reimbursement of their services. In fact, the Department of Health and Human Services has instituted a wide array of administrative cutbacks in the home health benefit. The agencies face inconsistent and increasingly restrictive interpretations of Medicare guidelines by HCFA. Home health officials are reporting that they have to care for sicker patients, many of whom would have remained in the hospital in the past, while at the same time the Reagan administration is making a conscious effort to reduce Medicare expenditures to home care.

In 1985, HCFA published a rule which altered the way home health costs limits are calculated under Medicare. Under this rule, most agencies are forced to limit or simply not offer at all high-tech and other costly services. Some agencies have been forced to completely deny access to heavy care patients. The administration has also repeatedly tried to eliminate the waiver of liability presumption, which protects agencies who, in good faith, provide Medicare services to individuals who are later determined to be ineligible. Ironically, while hospitals are discharging more clients who are in need of intensive nursing and physical therapy, the home health agencies are being denied reimbursement with the excuse that the patients they served were too sick to qualify for their services.

When the Medicare Program was established in 1965, Congress made clear that it intended for beneficiaries to have access to home health care, and the demand for this service is expanding more rapidly than ever. Home health care is cheaper than either hospi-

talization or institutional care. It provides a reasonable and cost-effective way of filling the care gap created by earlier hospital release. The administration's attitude toward home health is not only short-sighted, but appears inconsistent with its stated goals of cost containment and quality assurance. It appears that the administration has again considered only the immediate budgetary advantages of benefit reduction without considering the long term-cost effect of its actions.

The question we are exploring today, whether the quality of services to Medicare's 30 million beneficiaries has suffered is an extremely serious one. I am convinced that we can reduce our Federal deficit without turning our backs on the elderly and the sick.

I urge the committee to make a thorough investigation of the allegations that some of our senior citizens are being released from hospitals before they are physically ready. I hope the committee will go beyond merely identifying the problem and will take the lead in searching for solutions. Finally, I hope the committee will include in their list of recommendations the need for a fair and reasonable Federal policy on Medicare reimbursement for home health care.

Mr. Chairman, I understand that our colleague, Congressman Wright, had hoped to be with us today. I do not know if he has been able to join us. I do not see that he is here. And I know that Mrs. Sarah McClendon is with us, and Congressman Wright intended to introduce Mrs. McClendon, but I will be pleased to do that at this time if the chairman would like.

The CHAIRMAN. Mr. Frost, first of all, I would like to compliment you on the statement you have made. I think it is an excellent statement and definitely gives important information to this committee. Second, I would like to have you introduce the distinguished lady next to you, and I ask you to proceed.

Mr. FROST. If Mrs. McClendon would come forward.

I think many of you who have followed national politics over the years already know Sarah McClendon. But I would take just a moment to say that she is a Texas journalist, and has represented a number of Texas newspapers over the years; has been an active force in this capitol for many years, and I won't recount how many unless she prefers to tell you that. While she could be classified by some as a senior citizen, she is still an active reporter. And she is probably best known for some of the questions that she has asked at Presidential news conferences. Some of you will recall that she is not bashful, and she is not intimidated by anyone in public office, whether he be on the local level or whether he be President of the United States.

At this point I would like to present to the committee a fellow Texan and an upstanding person who has some personal insights she wishes to offer to the committee. Sarah McClendon.

The CHAIRMAN. Thank you, Mr. Frost.

May I welcome you, Mrs. McClendon. It is a real honor for the committee to have you present today, and I ask you to proceed in any manner that you may desire.

STATEMENT OF SARAH McCLENDON, PRESIDENT, McCLENDON  
NEWS SERVICE

Mrs. McCLENDON. Thank you, Mr. Frost.

Sir, I appreciate very much the opportunity to be here. I will be direct because I know you do not have too much time.

I was pursuing a news story which I was put onto by a doctor in this town, that so many patients, especially the elderly, but not altogether the elderly, were being discharged from hospitals too soon. And I knew as a result of that I would do an investigation. And I found out that this was a national problem of considerable importance. I found out that we just had to do something about it. And, of course, that means Congress. The people all over the country are looking to Congress to do something about this.

This is a national problem. And I know from the reaction I have had that this is a much bigger story than I ever had any idea when I got into it. I would say from the testimony that I have heard here today that there is a great need for Congress to attack this with every—all barrels going. And I would say that we have to be quick and we have got to do it in a hurry.

In the first place, you can see that this dear, good doctor, I am sure he means well, but you can see that he is not really knowing what is going on in these hospitals. And he ought to disguise himself or do something, and get out there as a Robin Hood and find out from somebody what is really going on. And you can see that Helen Bentley knows what is going on because she has just come from the hospital. And her testimony there is absolutely right testimony.

From what I have found out from the reaction that I got from people all over the country, they are looking to their Government for help. They are frightened. They are frightened that they will not be able to get into a hospital, they are frightened that they will not be able to stay long enough, they are frightened they will not be able to pay for it.

A woman called me up from a hospital in Washington and she said, "I am the cashier at one of the biggest hospitals in Washington. You can see the tragedy that goes over my desk every day from people who are being put out too quickly and people who are not able to pay for what they are required to pay for, and they did not know that they were going to have to pay all that." It really is a shame.

And, also, I note that it seems to be nobody—because I am still investigating my story, I am still looking into it. And I am not a technician. But from what I can gather, there is nobody keeping tabs on how many of these people die as a direct result of having been put out too quickly, then maybe being put back into the hospital a day or two later. Then by that time it is either too late or the disruption—maybe they are sent home again and then they die.

But I have had letter after letter in my office from families where this is happening.

Everywhere I go across this country, and I have been in about eight States lately, the people are all saying please do something, please tell Congress that we need something to be done quickly. I will tell you what we need, and I know what the people want. I



don't know whether Congress has got the guts to give it to them or not, but what the people want is for the Government to give them a national comprehensive health care plan. And that is what they need. And you will not be able to patch up what you have got now and do anything really constructive by adding a little here and a little there. What you have got is a rotten system.

You cannot take human beings and relegate them to the diagnostic group plan. You cannot do that. People do not stay in categories. It is a very very weak system that we have now.

There have been several approaches to this over the years, but you know that the people—Truman tried to get this through and couldn't. Kennedy tried to get more health care for the people. But, actually, there have been elderly people in this town working in coalitions for over 20 years trying to get something done about this.

When Ronald Reagan said on January 7 in a reply to a question I asked about solutions to the discharge policies of hospitals, he said that he has been looking into the financial strengths of catastrophic illness and that he has been studying it, and he hopes to get something done. Well, that was very fine. I am very glad to see that the President has opened the door to a study on this, and he has opened the door on action, I hope. But nobody really can find out exactly what he plans; not even his advisers will tell you that they know exactly what he plans.

Now, he went further in his State of the Union Address and he talked about some connection with private insurance industries. I understand that the private insurance companies met with the President before he went on, and they tried to get in there. Well, I do not know what he had in mind, but I can tell you right now that that is a long time off to getting any help that way. And, besides, it will help only about 80,000 to 90,000 people if you go to the catastrophic illness plan. That is only seven-tenths of 1 percent of the population.

Every day we delay, more people will die or be in misery.

I asked the President on January 7 if we could not study the feasibility of the health system in Canada whereby the people pay some comparatively small sums on their taxes and in return get full, adequate, quality health care for everybody, from the cradle to the grave. I do not know why Canada can have this, as small a country as that is, and we cannot. Somebody is scared of using the word "socialized medicine." I don't care what you call it. If this is treason for me to ask for socialized medicine, then make the most of it.

The President made promises about what he would do on this, but I am sure some motion was made of this when Prime Minister Brian Mulroney of Canada visited here. I asked Mr. Mulroney what he thought of the Canadian health system, and he said, "We have the best health care system in the world, and we would not trade it for anything." And he has gone through several administrations.

There are two outstanding men who have given us quotations on our present health system. President Reagan told the Congress this year that we have the best health care system in the world. Cardinal Joseph Bernardin of Chicago says the United States has the worst health care system of any nation in the North Atlantic coun-

tries, even worse than some of the undeveloped countries. He further points out that half of the poor cannot get the health care and fully—35 million persons could get no health insurance and are therefore left out.

David Resnikoff of Silver Spring, MD, chief health spokesman for the Grey Panthers of Montgomery County, has been trying to get national health service for the United States for 20 years. He says that in addition to all of this, and the millions who have inadequate health insurance programs, there are 10 million children in this country today who have never seen a doctor. How can children of the future learn technology and math and operate sophisticated weapons in national defense if they do not grow up with good health. How can people who do not have health care produce goods and services and wealth for themselves or for the Nation.

From the widespread reaction I had from people in all parts of the country after I asked that question of the President, I am convinced that people want a national health service plan. But we need it now.

I have been told that Congress wonders if people really want improvement in their health delivery system. This may be from the very suggestions made by national organizations. They haven't all gotten together. Of course, there have been several different bills offered in Congress.

A meeting was held in Chicago recently of these organizations that want national health service. I understand that they did make some attempt to get together.

That great statesman, Dr. Arthur Fleming, who served in the Cabinet of Presidents of both parties, has told friends lately that he thinks that we will get it in the 100th Congress. But that is going to be a little late; we need it now. We cannot wait that long. Why should Canada, a much smaller country, have such an excellent system and we such a rotten one? Somebody said we have a great health system. It may be great in spots. Sure, we have got good health equipment, but that is for the rich and that is not for everybody.

The Veterans' Administration, of which I was recently a patient, has far a better health system than any of the private sector, far better. Of course, someone said to me that the Veterans' Administration provide socialized medicine. Maybe it does, but I found out there in that hospital on Irving Street that you can get your toenails fixed, you can get your brain examined, and you can find out about Alzheimer's Disease and the whole gamut right there. They told me,

Ronnie Reagan should have come in here to have his cancer looked at. We would have taken any slob off the street who came in here and said he had a pain in the tummy. We would have put him through this cancer treatment that we've got out here, and we would have known right away what he had, and we would have done something about it.

So maybe Mr. Reagan better go out there next time he's a veteran.

But the fact that the Veterans' Administration has such a good system does not help the rest of the population. We have got to do something. We have got to have full, adequate quality care for all.



I don't know how in the world we are going to get it, but I am sure that you people can write it.

We are the only country besides South Africa—and who wants to be associated with them—we are the only country besides South Africa in the western civilized nations that does not have this health care system. As Cardina Bernardin said in Britain in 1982, when they only took about 5 percent of their gross national product for their health system, they had far less infant mortality rate than we do, and our rate is climbing terribly right now.

I have seen some of these health systems work out. My daughter lived in Britain and she lived in Canada. She lives in Canada today where she enjoys this health system. In Britain, she had a child. My grandchild was ill at 10 at night, as a baby and a doctor from this terrible socialized health medical system came to the home at 10 at night and took care of the baby. It is not true that they never have any close personal relationship with their doctors. They are assigned a doctor and they keep him over the years. In Canada, my daughter had the same doctor for years. She can talk to him on the telephone. You can go down there and get yourself waited on. You do not have to wait, my friends. You do not have to wait for an appointment, you do not have to wait for anything. You can go right in there and you get it. Her husband had pneumonia. He was in the hospital for 2 weeks. He had all the greatest and latest equipment. He never got a bill. All she had to do was give his name when he went in. She didn't have to go through a whole bunch of questions.

So I tell you right now that it really works. I am sad to see—if you could just see the pathetic letters. Like a woman called me the other day and said, "I am a professional woman. I have got to leave my job and go down to Florida to live and put diapers on my grandmother because there is no other way she can get help from any hospitals or nursing homes that care."

Now, I tell you right now I have had a lot of experience lately with the home health care people. They are the ones that I have heard from most. But do you know what has happened in the last few days; I am sure you know about it. All of this stuff about the agency that this good doctor represented here doing his part, let me tell you something. They did not put those orders out for the hospitals to give the patients notice until January 8. They may have been thinking about it, but mainly they were doing it under the pressure of this People's Medical Society up here in Pennsylvania. They weren't doing it on their own. They finally put it out. That does not mean anything. It means that you call for appeal and you get about 5 days grace before you have to leave the hospital. Those poor peer review groups stink. That really ought to be examined. Half the time you can't find it; nobody knows where it is or where it meets or who is on it. There is very little representation besides doctors on it.

For our Government to abdicate its responsibilities for its people, the people look to the Government for protection; the idea of our Government abdicating the responsibility for writing the laws and regulations which they submit to you, which they recommend, they let the hospitals and the doctors and the insurance companies—I do not blame the doctors in this as much as I blame the insurance

companies. The day this huge insurance lobby that runs out here in Congress, that has so much influence over Congress, wouldn't even let poor women get any equality for insurance because of the way—and under the law is no help for women because of the way the insurance lobby works.

You ought to be aware of this insurance lobby. The hospitals say nothing but costs have gone up, up, up. The way they treat these patients in these hospitals by putting a chart—you know they put the chart for the nurses to see what the patient's fever is, they put that on the bed. They have another chart over there that says how many more days you have in the hospital. Every day they rip off a page, and then the poor patient knows that he has got to get out pretty quick. Nobody but nobody is looking out for those poor—

The old lady the other day who had to leave the hospital, she was half-blind. She had nobody to look out for her when she went home. I think it is a shame and Congress should do something about it.

Thank you, sir.

[The prepared statement of Mrs. McClendon follows:]

PREPARED STATEMENT OF SARAH McCLENDON, PRESIDENT, McCLENDON  
NEWS SERVICE

Mr. Chairman and members of the Committee: I thank you for this opportunity. I will be direct.

While pursuing a news story on reports that hospitals were discharging elderly patients before they were well enough to go home, I learned that this is part of a much bigger story. What really is involved here is the entire health care picture of the nation.

The people need a national health care law that will give them adequate, quality health care for all the people. Not just the rich and not just the elderly poor, who can get into hospitals if it is an emergency. All the people need this, including the millions who now are denied it. Further, the people want this now. They needed it yesterday.

While there have been offered several approaches to this problem through legislation, in recent years, the truth is that none of these could give the people adequate, quality care for everybody.

The people have a right to life, liberty and the pursuit of happiness under our Constitution. "Health", essential to exercising these rights, should not be approached under a system that would give it to only segments of the population.

President Ronald Reagan said on Jan. 7, in reply to a question I asked him about solutions to the discharge policies of hospitals, that he had been looking into the problem of how to provide some program to help those in severe financial stress because of catastrophic illness. I was delighted to get this answer to my question. It meant the President had been observant of the need and was studying it. He went further, putting this into his State of the Union address to Congress and mentioning some connection with the private insurance industry. I do not know what he had in mind. White House advisors do not give you the answer. Later the President asked Dr. Otis Bowen, Secretary of Health and Human Services, who had been working on some health plans of his own, to study the matter and come up with an answer by next December. That is a long time off. Naturally, Secretary Bowen is not going to reveal his plans to us before giving them to the President. But we need to do something to step up the action.

However, my friends, I would point out to you that there is no need in waiting for that. It would only bring relief if at all—and I doubt if there would be any relief from the insurance company route—to 80,000 or 90,000 people, about .7 of 1 percent of the population.

Every day we delay, more people will die or be in misery.

I also asked the President on Jan. 7 if we could not study the feasibility of the health system in Canada whereby the people pay some comparatively small sums on their taxes and in return get full, adequate, quality health care for everybody from the cradle to the grave. He made me no promises but I am sure that some mention of this was made when Prime Minister Brian Mulroney of Canada visited here recently.

I asked the Prime Minister at his press conference how this system was working out in Canada and he replied: "We have the best health care system in the world and we would not trade it for anything."

There are two outstanding men who have given us quotations on our present health system. President Reagan told the Congress this year that we have the best health system in the world. Cardinal Joseph Bernardin of Chicago says the U.S. has the "worst health care system of any nation in the North Atlantic countries, even worst than some of the undeveloped nations." He further points out that half of the poor cannot get health care and fully 35 million persons can get no health insurance and are therefore left out.

David Reznikoff of Silver Spring, MD, chief health spokesman for the Gray Panthers who have been trying to get national health service for the U.S. for 20 years, says in addition to the 35 million people who cannot get health insurance, and the additional millions who have very inadequate health insurance, there are 10 million children in this country who have never seen a doctor.

How can children of the future learn technology and math and operate sophisticated weapons in national defense if they do not grow up with good health?

How can people who do not have health care produce goods and services and wealth for themselves or the nation?

From the widespread reaction I had from people in all parts of the country after I asked that question of the President, I am convinced that people not only want a national health service plan but need it now.

I have been told that Congress wonders if people really want improvement in their health delivery system. This may be from the varying suggestions made by national organizations in testimony. But their theme is the same--the need for changes in the current system and for more health care is universal. There are coalitions of national organizations. One met recently in Chicago. They see Congress dragging its feet. However, Dr. Arthur Flemming, that great elder statesman on health matters, who has served in the cabinet of both Republican and Democratic presidents, and who now devotes his time to obtaining a national health plan, has told friends he thinks the 100th Congress may give it to us.

We cannot wait that long. Why should Canada, a much smaller country, have such an excellent system and we such a rotten one? Some one replied to me by saying in this country we had such wonderful equipment and best doctors and hospitals. I said we do have good ones but the system is only available to the rich and those in an emergency.

We could have full, adequate, quality health care for all at very little more than the combined health costs we are paying today if we would adopt the Canadian system. We pay about 10 percent of our gross national product for health care now, and Canada pays about 8 percent. In 1982, we were paying 10.6 percent and Great Britain 5.9 percent. But the difference is that the British and Canadian systems which cost less are available to all their citizens. And as Cardinal Bernardini said again, the infant mortality rate in Britain is far less than ours. Indeed, ours has been climbing alarmingly.

The U.S. is the only country beside South Africa in western civilization not to have a national health plan. Do we want to be classed with South Africa?

Out over the country where I have been traveling of late, people want this system but they are afraid the present Congress will not give it to them. Jack Flaherty of New Smyrna Beach, FL., who has just formed We the People, dedicated to obtaining national health for the U.S., says the people are far ahead of Congress in this field. He found big and small labor, Catholics, fundamentalist churches, small business, the elderly, retirees, all wanting it. He found people so impatient with Congress that they are thinking of writing their own legislation and getting a national referendum on the subject.

I found many doctors who think that the present rules for setting payments and lengths of stay for hospitals to be unsatisfactory. Of some 250 internal medicine doctors, two thirds did not want this. Harvard professors and New England journals have been carrying articles about the failures of the present system. And is it not true that Blue Cross and Blue Shield made a billion dollar error in projecting charges?

I found profiteering hospitals that are being paid in lump sums for patient care under the present system to be literally blackmailing doctors who do not go along with the early discharge of patients. These doctors are being told that if they do not improve their record for discharging patients quicker, they might not be allowed to admit patients there any more.

All the time, as costs that Medicare will pay get less, and patients are warned to have bigger pocketbooks when they come to the hospital, the insurance companies are advertising on television and by daily mailings to get older patients to buy more supplemental insurance. This is costly and in many cases, non-deliverable. Elderly patients had better get some one to read the fine print of these policies.

Congress should beware of the heavy lobbying efforts of the insurance and hospital industries to keep the present system with only moderate changes. Actually the present system is one where the federal government abdicates its responsibility to help the people and turns responsibility for the system over to the hospitals, the insurance companies and the doctors. It is nauseating to see how the Health and Human Services' subsidiary, Health Care Financing Administration, leaves the policing of this system for hospital stay and payments up to a group of other doctors in each state, who often are non-performing.

No wonder some Americans want to move to Canada to take advantage of their system. The same holds for Britain, although she has other problems now. But in London, a doctor came to the house at 10 p.m. when my granddaughter was ill. Can you get that here? In Canada where my daughter and her family now enjoy the privileges of what some derisively call "socialized" medicine, they have the best of care at all times for a slight increase in taxes. My son-in-law had pneumonia. The hospital on entry asked two questions, his name and health system number. After two weeks, there was no bill. The family use the same doctor assigned them some years ago.

Come on, ladies and gentlemen. Who's fooling whom? We don't have to keep putting up with this same old song that hospital costs are going up, labor costs are up and doctors must be paid more for their skills.

I hope you will take on this courageous task and give the American people what they want and need and what they have no chance of getting now. I hope you give them full, adequate, quality health care under a national service plan.



The CHAIRMAN. Thank you, Mrs. McClendon.

May I first of all state that I compliment you on that very forthright statement and say that I agree wholeheartedly with your contention that what we need in this Nation is a national health plan. I believe it so deeply that I have been devoting the last 2 years to the development of such a plan which I intend to introduce within the next 30 days. It is called U.S. Health, and it does cover catastrophic care and medical care for all Americans.

I am sure that it is going to be criticized. I am sure that it is going to be a subject matter of discussion. But it is going to need persons like yourself to help in getting it through the Congress of the United States.

There is one question that I would like to ask. But before doing that, I would like to give you a summary of this U.S. Health Plan before you leave.

# USHealth

## An American Healthplan

Edward R. Roybal  
Chairman, House Select Committee on Aging

The "USHealth Program Act" (H.R. 5070), introduced by Representative Edward R. Roybal in 1986, is designed to control health care costs for all Americans whether they be individuals, employers or government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illness.

**Cost Containment.** The health care cost containment program covers all services and patients. In the short term, the cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Future increases are limited to increases in the per capita GNP. States may set up alternative payment programs. In the long term, a major vehicle for containing costs is through HMOs.

Cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the catastrophic limits described below. Cost sharing is optional for those enrolled in qualified HMOs. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

**Cost.** Target cost for USHealth is approximately 12 percent of GNP for the next 25 years.

**Access.** Financial access is ensured by making every citizen and resident eligible for "USHealth."

**Benefits.** Beneficiaries are protected from the cost of catastrophic illness. Their financial risk is limited to paying coinsurance as follows: a. up to a maximum \$500/person/year, pays 20% of health care and skilled nursing home and home health costs, and b. up to a maximum \$1,000/person/year, pays 25% of non-skilled long term care costs. Both "maximums" are indexed to per capita growth in GNP.

Basic health benefits (similar to Medicaid "categorically needy" package) include: inpatient and outpatient hospital services, physician services, rural health clinic services, laboratory, x-ray services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), preventive care, prescription drugs, physical therapy, occupational therapy, medical equipment, prosthetic devices, orthopedic shoes, nursing home services, home health services, respite care, outpatient mental health care, inpatient psychiatric hospital services, basic dental care, vision care and other medical or remedial care recognized under State law and specified by USHealth.

**Quality.** The current federal quality assurance system consisting of Peer Review Organizations (PRO) is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all medical services (hospital, physician, nursing home, home health), set up a national Council on Quality Assurance, and add Consumer Advisory Boards to PROs. States have the option to develop their own qualified quality assurance system. Quality assurance is also addressed by federal qualification of HMOs.

**Administration.** The program is entitled "USHealth" and managed by the USHealth Administration (currently, Health Care Financing Administration) which is independent and off-budget.

**Financing.** Health care cost increases will closely match increases in per capita GNP -- approximating the Nation's ability to pay. The provisions to ensure financial access for all Americans are financed as follows: the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing, an expanded cigarette tax, extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Part B premium"), an employer tax based on compensation, State revenues covering 1/2 the cost of the poor, and a surcharge on corporate and individual income taxes sufficient for solvency of USHealth.

For further information on USHealth, contact the House Select Committee on Aging at 202-226-3375.

The CHAIRMAN. Before you leave, I would like to ask you this question. It has been my experience, as I go among senior citizens throughout the country, as we hold hearings and talk with them, that they are reluctant to admit in most instances that they were discharged earlier. But they do admit that they were discharged sicker. In talking to them, they say, "Well, we don't want to blame the hospital because we may have to go back."

Mrs. McCLENDON. That is exactly true. There is a lot of intimidation by these hospitals, and a lot of it is on Congressmen. Don't think that it isn't. When they come up here with these big receptions that they give right here in this building when they come to town at night for these Congressmen, I shudder to think about it.

But the intimidation of the hospitals is on the doctors. I heard from a lot of doctors who say that the DRG system and the prospective payments plan will not work. You can go to the Internal Medicine Association of Doctors. I think 254 are in the group. And two-thirds of them are very definitely against it.

The doctors tell me that they are intimidated by the hospitals to a great extent. They tell me that the hospitals blackmail them that doctors are supposed to give their word on discharge of the patient. And if the doctor does not want to discharge the patient right away and thinks the patient should not go, the hospital may come to him and say, "Now, look here, sir. We have a record here of you having patients in here that overstay and stay too long, we think. And we don't think you should let these patients stay in here this long. And, sir, if you keep on with this, if you can't figure out a way to get your patients out of here, we may not let you bring patients back to this hospital again."

Now, that really goes on in this country, believe it or not. The doctors are pretty sick of it. I think you can find plenty of adequate documentation in the New England Journal of Medicine and the doctors in New England, who are considered very fine, who are now coming out wholeheartedly opposed to this system and saying that we need a national health service plan.

The CHAIRMAN. Thank you.

Mr. Wise.

Mr. WISE. Thank you, Mr. Chairman.

Mrs. McClendon, I also want to echo the chairman. I also think we need a national health insurance plan and feel that it is scandalous at this point that we do not have one.

I would like to ask if you have made this observation. I live in a rural area in West Virginia. And I have seen over the past few years much more of a profit incentive creep into the health delivery system. In some cases, that has resulted in new and shinier buildings. We now have outpatient centers that are treating people far cheaper than it costs to go to the emergency room.

So I think in some areas perhaps there have been some benefits. But underlying the whole thing, there is a disquieting element to me, and that is the profit incentive. Are we doing it for dollars?

I went to a nursing home the other day in a rural part of the State, a very shiny nursing home. But the bottom line is it's a proprietary hospital, it's a proprietary nursing home. If they are not able to deliver that health care and make a profit for stockholders, then they are not interested.

I guess that is my real concern about where we are going in health and medical care delivery in the future because we keep going down that road. And I think the horror stories you are talking about are just going to multiply.

I just wonder if you have any observations in that area.

Mrs. McCLENDON. Well, sir, this is true. That is why you have got to have the Federal Government.

I am a Texan, and you know how Texans are. They say, "Oh, we don't like the old Federal Government up there." We have got to have this arm of protection for all the people. You will have special interest people, you will have selfish people doing this, exactly the thing you—looking for profit.

Of course, the other day I was quite amused when the Texas Hospital Association was in town, and I asked the executive director how many of his hospitals were profiteering. He said, "Oh, I wouldn't know." I am afraid a lot of hospitals are profiteering.

Mr. WISE. I have also learned from some of the work in our legislature that even the nonprofit hospitals, they don't make a profit, but they run a surplus. And then they put that someplace that benefits—

Mrs. McCLENDON. Well, what's the difference?

Mr. WISE. There is no difference, and that is my point. So one group gets called a—

Mrs. McCLENDON. The point is that I am sick and tired—for years I have been covering this Capitol Hill, and I am sick and tired of hearing someone say, "Oh, the hospitals tell us." I said what are the hospital people in town, what are they asking for this time, what do they want. "Well, they want more money because their costs have gone up." Well, why in the name of God can't we have a Federal Government that puts a ceiling on those costs, or why can't we put a curb on those costs? We cannot continue just to give the hospitals all the payments that they want. The people cannot afford this. And do you like people or do you like hospitals?

Mr. WISE. Thank you very much.

The CHAIRMAN. Mr. Wortley.

Mr. WORTLEY. Thank you, Mr. Chairman.

I applaud you, Mrs. McCleendon, for your strong advocacy for better health care for all Americans, regardless of their age. You do it with great gusto, I might say.

There are, indeed, some laudable aspects of some of the universal health care systems. But from what I have been able to observe, there are also tradeoffs. For instance, over in England under their universal health care—and I had a good friend who was over there not too long ago who had a ruptured appendix. They took him to the hospital, he was well treated, and never got a bill. He was an American citizen, incidentally.

But I also know that under England's health care system people who are over 65 are denied the services like kidney dialysis. As I said, there are tradeoffs. And I am not so sure that we in America, in our—if you want to call it free enterprise-oriented medical system, are willing to make some of the sacrifices.

You alluded, I believe, to your daughter. You said she was in Canada, and she does have the opportunity to go to the same physician and counsel with him regularly. But when you are talking



about a nation of 235 million people versus the numbers that they have in Canada today, that is a big big business.

Mrs. McCLENDON. Well, sir, let me tell you something. Canada does it for eight-point of their gross national product. It is well estimated and documented where you can take good stuff from the staff of this very committee and find out how much we could do it. We could do it for about—we are spending, I guess, now about 10 percent of our gross national product on health.

Mr. WORTLEY. Yes. I just—

Mrs. McCLENDON. And look what we are not getting. Look what we are not getting. That is not for everybody. That is not helping everybody. Look at the big gaps. And they are spending it on all of their population.

According to the staff work that is available to Congress, we could spend not much more than all of the money we are spending on health care by everybody today and have this system. And we would give it then to everybody. We like all of our citizens, not just the rich.

Mr. WORTLEY. Do you have any recommendations? And I am asking not to be an adversary, but do you have any recommendations as to how we attempt to contain some of these health costs? You alluded to the hospitals and my colleagues out here. Whether they are making profits or not, believe me that I share your concerns. But we do know that health care costs, particularly hospitals, have been at least 50, sometimes 75 percent higher than the cost of—increases in the cost of living in the rest of the Nation.

Mrs. McCLENDON. Well, that is what the hospital people told you. I bet nobody has gone in there to see how much they could cut down. They are trying to make profits.

But I have been told this recently, and I have not invented it. And I do think it is something that you might look into. I was told by a medical laboratory technician the other day that she tried to get into work for—she had come out of the Army where she had been trained, and she tried to get into the private hospitals to work. Well, they looked her over and said, "No, no, you can't come in here because you haven't graduated from this or that or this college." And she said it's poppycock. When you look out here at the large number of unemployed people right here in Washington who have had some health care training, who would be willing to work in the hospitals who were denied employment; she thinks a lot of it stems from the fact that some of the hospitals may make too much—too big requirements for some of their employees on their education. I do not know—

Mr. WORTLEY. Well, I think they are aspiring to a quality of health care, obviously. And before our very own committee not too many months ago, we investigated the issuing of medical credentials. And we discussed the situation where so many people were getting diplomas and degrees from medical schools in the Caribbean, coming in here taking jobs as interns who really were unqualified. And the horror stories we heard would curl your hair.

Mrs. McCLENDON. Well, you know those people down in Grenada who couldn't get into medical schools here—I don't know why they couldn't get in, but they were down there studying medicine in



Grenada. And that is why we had to have the invasion and the conquest down there.

Mr. WORTLEY. Would you in your experience have any statistics or rough figures you might quote us as to quality of health care, as you understand it, between the so-called not-for-profit or public hospitals versus a for-profit medical institution?

Mrs. McCLENDON. Well, I don't know. My only experience has been with—I am very healthy and I have only been to the Veterans' Administration.

Mr. WORTLEY. They have taken good care of you?

Mrs. McCLENDON. And they have the best. And, also, it is not generally known that they train 40 percent of the doctors that we have in this country. And the doctors don't always tell you where they get part of their training.

Of course, right now, you should begin to looking into training. You know, I guess, that the medical schools are charging so much tuition that the boys and girls who cannot get into medical schools or can't pay that are now going into the ROTC, and they are now going into the Navy and the Army and letting the taxpayer pay their tuition for medical training that way. And I don't condemn this. I think it is going to give us some medical training. But I just think the Congress should realize that the taxpayers are paying for this largely because some of these medical schools would not let the students in, or would not let them in under a decent tuition. And that's another thing you might look into.

Mr. WORTLEY. Well, I think the economics of it is a key consideration. Very few parents can afford to send their youngsters to Georgetown—

Mrs. McCLENDON. You're right.

Mr. WORTLEY [continuing]. Medical School.

Mrs. McCLENDON. And it goes up every year.

Mr. WORTLEY. Right. It sure does.

Mrs. McCLENDON. Now, before I leave, Mr. Chairman, I want to tell you something. I am sure you know this, maybe. But I want to be sure that they all know about it.

Recently, there has come a directive from Miller's office, that man who took David Stockman's place. You know David Stockman; I'm sure you remember him. Well, anyway, this Mr. Miller down there has issued a directive which I think is absolutely not ethical and absolutely not right. And if I did it, if I applied these methods to pad my bills as an individual, I would be put down as a bad credit risk pretty quickly.

But Mr. Miller has given instructions, and Mr. Bowen has gone along with it, and it is now openly the established practice of the government to delay the Medicare payments and Medicaid payments to hospitals and other places where they are paying, and to delay the payments to the home health care payments and to nursing homes; delay as much as even 30 days and use that interest that they are getting; says that will help the Government's financial situation. Now, I think that is a crime.

The CHAIRMAN. Thank you very much.

Mr. Vento.

Mr. VENTO. I don't want to—you're like a breath of fresh air, that's for sure, in terms of these issues. And we appreciate it. I

think that you have discovered that there is a process—really, I think the reason we put this prospective payment system in place was to try to get a handle on health care costs. We would not put a ceiling limit on hospital costs, you know, back in the late seventies. So we tried this particular system. And the real flaw in it is that there is not any appeal process that is workable. In other words, nobody is there to advocate for patients, not even the doctors, who are at a disadvantage, as you pointed out.

So I think your comments today have been very helpful, right on in terms of what is happening.

The real problem here is that before we ever get a national health insurance program, we have to make certain that we somehow can hold accountable the various vendors, the various individuals giving the service to the system. That is really where we are at.

Mrs. McCLENDON. Oh, I don't think you would have a bit of trouble with that. You could write that into the rules very easily, if the Government were doing it. If you leave it to private individuals to do it, no go.

Mr. VENTO. Well, that is the problem. The day they send the patients out of here, and they have got a computerized bill just after having a gall bladder removed or something, and they are supposed to challenge the hospital bureaucracy as to what the costs were in that particular computer printout of a bill. Well, you know, you are not going to get much accountability out of that type of system. So we are trying something else now, and I think we are discovering some problems with it.

The truth of the matter is, Mr. Chairman, and to the witness, we are going backward. Medicare used to cover about 80 percent. Today it covers a little over 40 percent of the elderly's bill. So we are providing less care than we did. And even with this catastrophic business, don't be misled. It might have a good purpose, but it is very very narrow in who it applies to. If you are on the way to the Pearly Gates—God bless you—maybe you might get some health out of that if you are in the hospital long enough. But that is about the focus of that particular program. It is very narrow, and it does not do a whit in terms of dealing with some of the problems we are talking about. But by and large, the problems that the elderly are experiencing in nursing care facilities, in drugs and other things that are not hospital related. So we have several problems here.

Mrs. McCLENDON. Sir, I think as far as numbers are concerned, numbers of people who are involved, you ought to realize that this has an effect not only on the elderly patients, but on their families. In some cases, they are elderly people over 70 years old having to take care of the 80-year-old patient who has come home too soon from the hospital. And finally that elderly person, that 70 year old breaks down. And the younger people in the family are being called in to work on this. And the whole family is disrupted by this. They have got to have some help. And the—it's a shame that the Federal Government is abdicating its responsibilities. And I hope Congress does not. I hope they give them some protection.

The CHAIRMAN. Thank you, Mrs. McClendon.

Mrs. McCLENDON. Thank you.

The CHAIRMAN. Thank you very much for your testimony this afternoon.

The Chair now calls the final panel. It is made up of Dorothy Seeley, Dr. John Dawson, and Robert Stutz. Would you please come forward.

Mrs. Seeley, would you please proceed in any manner that you may desire.

**STATEMENT OF DOROTHY SEELEY, MEDICARE BENEFICIARY  
AND REPRESENTATIVE, LEADERSHIP COUNCIL OF AGING OR-  
GANIZATIONS, MILWAUKEE, WI**

Mrs. SEELEY. Mr. Chairman, I am Dorothy Seeley. And I have come to Washington to tell you about the experiences that my husband, Harrison, and I have had with the recent hospitalization and home care. We are both Medicare beneficiaries. Harrison is 72 and I am 70 years old. Harrison could not come with me because of his condition. Last Monday, I brought him home from the hospital where he was treated for pneumonia in one lung. This Monday I took him back to the hospital, 1 week later, with acute bronchial pneumonia in both lungs. I really think he was sent home too soon—for a week. Have you ever watched a loved one struggle for breath even with oxygen at home?

Today, I am speaking on behalf of the Leadership Council of Aging Organizations. It is a coalition of 30 national groups which serve to represent the elderly. I have a list of the Leadership Council members which I would like to submit for the record.

The CHAIRMAN. Thank you.

Mrs. SEELEY. I am president of the Allied Council of Senior Citizens of Wisconsin, Inc. We are the largest grassroots organization of seniors in Wisconsin. The Allied Council is affiliated with one of the members of the Leadership Council of Aging Organizations, the National Council of Senior Citizens. The Allied Council is the leading voice for Wisconsin's elderly.

The Leadership Council asked me to testify because Harrison's and my experience is an example of the kinds of situations that seniors all over the country are finding themselves in after they are hospitalized.

Most of our problems started last May. Harrison was in the hospital five times in three different hospitals. I was hospitalized in 1984. Harrison worked as a carpenter most of his life. His health was very good. Nine years ago, the doctors discovered that he had multiple myeloma. Since then, he has had back pain, but it didn't stop him from working. After retiring at age 67, he started working in the wood shop at our local senior center.

Your honor, I have a product of my husband's workmanship to present to you. And I hope you use it well.

Harrison had a routine physical exam last May. The doctor spotted a small tumor on his bladder, which was removed under spinal anesthesia. He spent 1 week in the hospital. His back became flared up. I thought that the spinal anesthetic caused his pain. We wondered why the doctor used that method, knowing that Harrison had a history of multiple myeloma and back pain.

They sent him home from the hospital even though he had trouble walking because of pain. Nobody tried to find out what was causing it. It seems to me that all they cared about was what he went into the hospital for, the bladder surgery. No one seemed to care about what he went home with, back pain.

Harrison recovered fine from the surgery, but not from the back pain. After his discharge, Harrison went back to his woodshop job for 1 week. He had trouble walking. Finally, I said, "Harrison, enough is enough. I'm taking you to the doctor."

We went to the orthopedic doctor who took care of me the year before. He put Harrison in the hospital, not the same one where he had the bladder surgery. I drove him to the hospital. The doctor put Harrison in traction, and after 6 days the doctor came into his room—and I'll never forget it. He stood at the foot and said Harrison had to go home. He told us that Medicare's DRG's would pay for only 7 days of traction. I told him I can't handle him. The doctor knew that I had spondylosis and two fusions in my spine. I also had three osteotomies and half of one of my knees is an artificial replacement.

I said he's not ready to go home. He said, "Dorothy, I have to put on a different hat now. The hospital administrator is on my back, and Harrison has got to leave. I know he is not ready to go home and you know he is not ready to go home, but he has to go."

Well, Harrison went home on Saturday by ambulance. Can you imagine; I drove him to the hospital so that he could have his back pain treated. Yet when the hospital let him go, he was taken home in the ambulance.

I called the doctor and told him how bad Harrison was feeling. He said to take him for a CAT-scan. So on Tuesday, just 3 days after he was discharged from the hospital, Harrison went by ambulance for the scan at the same hospital that had just discharged him. The ambulance brought him home after the CAT-scan. Two days later on Thursday, the doctor got the scan results; Harrison had cancer of the spine. He had three lesions on his lumbar spine. The doctor said he had to go to the hospital right away to begin radiation therapy.

The doctor said, "Where do you want him to go?" I asked him to recommend someone, which he did, and the ambulance came to the house and took him yet to another hospital. That was his third hospital in about 4 weeks, and his fourth ambulance ride in 5 days.

This is the survival of the fittest.

Mr. Chairman, that week, going from hospital to hospital and Harrison's pain was an ordeal that still brings tears to my eyes. It is difficult for me to find the words to tell you how he felt to hear the doctor say, "Harrison, you have cancer in your spine." It was a shock. After we got over the initial shock, however, we got angry and more worried.

We asked ourselves why in the world didn't the doctors at the first hospital look at his spine when he went for bladder surgery. He complained about his back. Why wasn't the diagnosis made before he was sent home in pain. Why was everyone so much more anxious to get him out of the hospital than to find out why his back hurt?



The worst part was wondering how much time was lost by not starting the radiation therapy sooner. The oncologist said we were lucky we came when we did, or he would have been in deep trouble.

Harrison and I suffered a lot. I tried to take care of him. I asked myself how can anyone get well when you are upset and aggravated. Now I wonder why isn't Medicare helping us as we thought it would.

I really didn't think it's fair. Harrison and I worked hard all our lives. We paid for insurance to help with our medical bills because we know Medicare does not cover everything. We believed that Medicare would at least enable us to get good hospital care when we were very sick. Now we are finding out that Medicare is trying to save money on hospital care, and hospitals cannot wait to get us out.

Nobody likes hospitals. But when you are sick, you expect to be taken care of. I do not think Harrison was really taken care of as he needed to be. He was just pushed around.

When Harrison got over his 15 radiation treatments, I took him home. That was after 5½ weeks. I had home health care that the doctor ordered, which they are trying not to pay for after October 1, 1985. We were told that he did not need any more care. And this is a lie, we were never told that he didn't—he couldn't walk. I helped him.

I was also in traction in the hospital for 6 days. The doctor came in one day and told me the Government said I could no longer stay there. He ordered traction to be sent to my home, and he discharged me. And that was a nightmare. I could not handle it by myself. Medicare ended up paying the bill for 60 days of home traction that I did not use.

Something is wrong with the DRG's. It seems that we are not allowed to stay in the hospital long enough for the doctor to find out what is wrong. When we need the care at home, the burden falls on others.

I think experiences like ours are not hurting just senior citizens. I think a lot of Medicare's money is being wasted. Medicare paid for Harrison's three hospital admissions in a 4-week period. Medicare paid five ambulance trips. I think the money Medicare paid out would have been much lower if Harrison's cancer was diagnosed when he had his bladder surgery.

No matter who is paying the bills, unnecessary expenses are unfair. When I think about how much money Medicare, in supplemental, paid just because the hospitals shuttled Harrison around, I think it is a terrible waste and it raises the insurance premiums. It is not just the money that worries me. The people that we trusted to take care of us seemed to put Medicare payments first. To them, the cancer hiding in his spine was secondary.

This should not have happened to us. It should not happen to anyone else. Please do something about it. And let me say that when the almighty dollar comes before a precious life, something is wrong with our society.

I just wanted to bring you my husband's favorite saying. He knows I am here. He says, "Remember you only have one time



around in this whole life. And the only mark you leave is that you left something better than what you found it."

[The prepared statement of Mrs. Seeley follows:]

PREPARED STATEMENT OF DOROTHY SEELEY, MEDICARE BENEFICIARY;  
AND REPRESENTATIVE, LEADERSHIP COUNCIL OF AGING ORGANIZATIONS,  
MILWAUKEE, WS

Mr. Chairman, I am Dorothy Seeley. I live in Milwaukee, Wisconsin. I have come to Washington to tell you about the experiences my husband, Harrison Seeley, and I have had with recent hospitalizations. Harrison is 72 years old and I am 70. We are both Medicare beneficiaries. Harrison couldn't come with me because of his condition. He has cancer. Last Monday I brought him home from the hospital where he was treated for pneumonia complicated by emphysema. Now he's back in the hospital again.

Today I am speaking on behalf of the Leadership Council of Aging Organizations. It is a coalition of 30 national groups which serve or represent the elderly. In Milwaukee, I am President of the Allied Council of Senior Citizens, a grass-roots organization which is the largest member-based senior group in Wisconsin. We have about 9,000 members. Most of our members are Medicare beneficiaries so we are very concerned about health care.

The Allied Council is affiliated with the National Council of Senior Citizens, a member of the Leadership Council of Aging Organizations. We were one of NCSC's first state councils. I am proud to say that the Allied Council is a leading voice for Wisconsin's elderly.

The Leadership Council asked me to testify because Harrison's and my experience is an example of the kinds of situations that seniors all over the country are finding themselves in after they are hospitalized. You know, it's really a shame: it's hard enough when we are so sick we need hospital care. But now we're finding that this can be just the beginning of our problems. Let me tell you what happened to my husband and me.

Most of our problems, which started last May, are related to Harrison's illnesses. He's been in the hospital five times, in three different hospitals, over the last year. I was hospitalized once in late 1984.

Harrison worked as a carpenter for most of his life. His health was very good. Nine years ago the doctor discovered that he had multiple myeloma. The doctor couldn't figure out where the primary tumor was, but somehow, miraculously, he recovered. Since then he has had back pain, but it didn't stop him from working. He taught woodworking at Hamilton High School and, after retiring at age 67, he started working the woodshop at our local senior center.

In late May of 1985, Harrison had a routine physical exam. The doctor spotted a small tumor on his bladder. He was hospitalized and the tumor was removed under spinal anesthesia. The tumor was malignant but non-invasive, and he did not need further treatment. He spent one week in the hospital. During that week, his back pain flared up so badly he could hardly walk. I thought that the spinal anesthetic caused his pain. We wondered why the doctor used that method knowing that Harrison had a history of multiple myeloma and back pain.

Well, they sent him home from the hospital even though he had terrible back pain. He had trouble walking because of the pain. Nobody tried to find out what was causing it. It seems to me that all they cared about was what he went into the hospital for--the bladder surgery. No one seemed to care about what he went home with--back pain. Harrison recovered fine from the surgery, but not from the back pain.

After his discharge, Harrison went back to his woodshop job for one week. He's like that, you know, never complains; he doesn't even want to take pain pills; he's a hard worker. But I could see how bad he was feeling. Finally I said, "Harrison, enough is enough. I'm taking you to the doctor." We went to the orthopedic doctor who took care of me the year before. He put Harrison in the hospital right away, not the same one where he had bladder surgery. I drove him to the hospital.

The doctor put Harrison in traction, but he still had severe pain. After six days, the doctor came into his room. I'll never forget it. He stood at the foot of the bed and said that Harrison had to go home. He told us that Medicare DRGs would pay for only seven days of traction. I told him, "I can't handle him. How can I take care of him when he's in such pain?" The doctor knew that

I had spondylosis in my back and had two fusions in my spine. I also had three osteotomies and half of one of my knees is an artificial replacement.

This is what the doctor told me. He said, "Dorothy, I have to put on a different hat now. The hospital administrator is on my back and Harrison has to leave. I know he's not ready to go home, and you know he is not ready to go home, but he has to go home." Well, Harrison went home the next day, on Saturday. He was in so much pain that he had to go by ambulance. Can you imagine, I drove him to the hospital so that he could have his back pain treated. Yet when the hospital let him go, he was in such bad shape, they had to call an ambulance!

When we got home the ambulance attendants tried to wheel him in, but their stretcher wouldn't fit through the door. Harrison had to walk a little. It hurt him so much he couldn't stand up straight. We finally got him into bed. That weekend was awful for us. Harrison could not do anything for himself. I even had to help him turn in the bed. I had a walker which I used after my knee surgery. I tried to walk Harrison with it so he could use the bathroom. It was so hard; I had to struggle to hold him up. We cried all weekend.

I called the doctor and told him how bad off Harrison was. I told him I was unable to comfort him and I was afraid I would hurt myself trying to help him. The doctor said to take him for a CAT scan. So on Tuesday, just three days after he was discharged from the hospital, Harrison went by ambulance for the scan to the same hospital that had just discharged him. When he was on the way to the hospital, I had to stop to get his X-ray from the hospital where he had his bladder surgery.

The ambulance brought him home after the CAT scan. He was in worse pain after the trip to the hospital. Every time he had to move, it was terrible.

Two days later, on Thursday, the doctor got the CAT scan results: Harrison had cancer of the spine. He had three lesions on his lumbar spine. The doctor said he had to go to the hospital right away to begin radiation therapy. An ambulance came to the house and took him to yet another hospital. That was his third hospital in about four weeks and his fourth ambulance ride in five days. We went to a new hospital because the orthopedic doctor recommended an oncologist who practices there.

Mr. Chairman, that week, going from hospital to hospital, and Harrison's pain, was an ordeal that still brings tears to my eyes. I don't know how we survived it. It's difficult for me to find the words to tell you how we felt. To hear the doctor say, "Harrison you have cancer in your spine," of course, was a shock. After we got over the initial shock, however, we got angry and more worried.

We asked ourselves: Why in the world didn't the doctors at the first hospital look at his spine when he went for bladder surgery? Why wasn't the diagnosis made before he was sent home in such pain from the second hospital? Why was everyone so much more anxious to get him out of the hospital than they were to find out why his back hurt so much? The worst part for us was wondering how much time was lost by not starting the radiation therapy sooner.

Harrison and I suffered a lot during May and June last year. He was in such pain during that weekend after he was discharged by the hospital where he had traction that he hardly remembers what happened. But I remember. I tried so hard to take care of him. My daughter helped me, but I was still getting very tired. My back was hurting, too. I asked myself, "How can I get well when I'm so upset and aggravated?" Now I wonder: why isn't Medicare helping us as we thought it would?

I really don't think it's fair. Harrison and I worked so hard all our lives. We saved our money. We bought insurance to help pay our medical bills because we know Medicare doesn't cover everything. We believed that Medicare would at least enable us to get good hospital care when we're very sick. Now we're finding out that Medicare is trying to save money on hospital care, and hospitals can't wait to get us out.

Nobody likes hospitals. Harrison and I certainly don't. But when we're sick we'll go to the hospital. We expect to be taken care of. I don't think Harrison was really taken care of as he needed to be. He was just pushed around.

When Harrison got over the hump after his radiation therapy, I took him home. That was after five and one-half weeks. By then I was able to take care of him with the help of the home health care that the doctor ordered. He went back to the hospital in late March with pneumonia. I brought him home last Monday. I still need help with him, but Medicare is threatening to stop



paying for the home health visits. (Just two days before I left Milwaukee to come here, Harrison had to go back to the hospital.)

My problems related to hospitalization started when I had back pain. I was in traction in the hospital for six days. The doctor came in one day and told me the government said I could no longer stay there. He ordered traction to be set up on my bed at home, and he discharged me. That's when my troubles began.

The traction equipment, which was rented, was delivered and set up. The visiting nurse came in once and tied the knots for the weights. Something was wrong with the traction. One of the weights kept swinging under the bed. Everytime I had to get out of bed to go to the bathroom, I had to unhook the traction. Then I couldn't get back into it. I tried to get someone to come in and fix the traction, but I got no results. Finally I called the traction equipment people and told them to take back the traction.

Medicare was reimbursing the rental, which was on a 30-day basis. I called for pick-up before the 30 days was up and they told me they didn't have a truck available. When they finally came, it was after another 30-day period had begun. I told them they couldn't charge me or Medicare for another 30 days since I called them in time, and it was their fault that they didn't pick it up. Well, they did charge Medicare for the additional 30 days. Medicare paid the bill for 60 days of traction that I didn't use.

Something is wrong. With the DRGs, it seems that we're not allowed to stay in the hospital long enough for the doctor to find out what is wrong. When we need care after we go home, the burden falls on our spouses or our families to take care of us. I think that experiences like we've had are not hurting just senior citizens. I think a lot of Medicare's money is being wasted.

Medicare paid for Harrison's three hospital admissions in a four-week period. Medicare also paid for five ambulance trips. I can't help but think that the money Medicare paid out would have been much lower if Harrison's cancer were diagnosed when he had his bladder surgery. We're lucky that our supplemental insurance paid our deductible and co-payments. But no matter who is paying the bills, unnecessary expenses are unfair. When I think about how much money Medicare and supplemental paid just because the hospitals shuttled Harrison around, I think it's a terrible waste.

It's not just the money that worries me. All this happened a year ago and I'm still upset. When I think back to those days in May and June, I cry. I get angry. The people we trusted to take care of Harrison seemed to put Medicare payment first. To them the cancer hiding in his spine was secondary. This should not have happened to us. It should not happen to anyone else. Please do something to stop it.

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LEADERSHIP COUNCIL OF AGING ORGANIZATIONS

American Association for International Aging  
 American Association of Homes for the Aging  
 American Association of Retired Persons  
 American Society on Aging  
 Asociacion Nacional Pro Personas Mayores  
 Association for Gerontology in Higher Education  
 Catholic Golden Age  
 Concerned Seniors for Better Government  
 The Gerontological Society of America  
 Gray Panthers  
 National Association of Area Agencies on Aging  
 National Association of Foster Grandparents Program Directors  
 National Association of Mature People  
 National Association of Meal Programs  
 National Association of Nutrition and Aging Services Programs  
 National Association of Older American Volunteer Program Directors  
 National Association of RSVP Directors, Inc.  
 National Association of Retired Federal Employees  
 National Association of Senior Companion Project Directors  
 National Association of State Units on Aging  
 National Caucus and Center on Black Aged, Inc.  
 National Council of Senior Citizens  
 National Council on the Aging, Inc.  
 National Indian Council on Aging, Inc.  
 National Interfaith Coalition on Aging  
 National Pacific/Asian Resource Center on Aging  
 Older Women's League  
 Retired Members Department/United Auto Workers  
 AFL-CIO Department of Occupational Safety, Health & Social Security  
 Villers Advocacy Associates

The CHAIRMAN. Thank you, Mrs. Seeley.

The Chair recognizes Dr. John Dawson. Would you please proceed, Doctor, in any manner that you may desire.

**STATEMENT OF DR. JOHN H. DAWSON, REPRESENTATIVE, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART AMERICAN MEDICAL ASSOCIATION DEPARTMENT OF FEDERAL LEGISLATION**

Dr. DAWSON. Thank you, Mr. Chairman.

Mr. Chairman, Members of the Committee, my name is John H. Dawson. I am a physician in the practice of general surgery in Seattle, WA. I am also a member of the board of trustees of the American Medical Association. Accompanying me today is Mr. Bruce Blehart of the AMA's Department of Federal Legislation. We are pleased to have this opportunity to appear before you to share our concern over the reality of Medicare beneficiaries leaving our Nation's hospitals while still in need of acute care.

The American Medical Association is deeply concerned about the impact of changes in the Medicare Program and the ability of physicians and hospitals to ensure the continued availability of high quality care services for the Medicare population.

We are concerned in particular that the prospective pricing system may be a step back from the gains of the past 20 years. The combination of the incentives for not providing care that are inherent in the PPS, and the fact that hospital reimbursement under this system routinely has been scaled back even prior to full implementation of the system points to increasing pressure to turn Medicare beneficiaries out of hospitals at a quicker rate, with all of the attendant problems of premature hospital discharges.

In response to your concerns over the impact of the PPS, I will discuss the AMA's DRG monitoring project.

Of the comments received concerning quality of care, two-thirds stated that the quality had deteriorated. Concerns have related to early discharges, limitations on laboratory tests, and hospital stays in which a second medical condition requires treatment.

Of the physicians' comments received concerning discharge policy, 43 percent reported that there was pressure to discharge patients early. The AMA DRG monitoring project focuses attention to the potential problem areas in the PPS. The facts cannot be ignored that physicians are under increasing pressure to discharge their patients too soon.

Mr. Chairman, the statistics generated by the monitoring project pale in comparison with the actual statements we have received from physicians, and that we have just heard from Mrs. Seeley, on how the PPS is affecting the care of their patients.

Our statement for the record sets forth excerpts from statements submitted to the monitoring project that spell out how individual physicians and their patients have been directly affected by the PPS. We are concerned that such examples represent only the tip of an iceberg, initial symptoms of what could prove to be a massive problem with the PPS. We are concerned that further squeezes on Medicare reimbursement will only increase these situations to the point where they are no longer isolated instances of system failure.

The AMA will continue to monitor the effects of the PPS through the DRG monitoring project and through the use of surveys. As part of the associations' 1985 socioeconomic monitoring survey of physicians, questions were posed relating to changes in medical services because of the PPS. On the issue of early discharges, 40 percent of the physicians reported that they have discharged Medicare patients from hospitals earlier than they had before the implementation of DRG. Of these physicians, 40 percent reported that the earlier discharges have worsened the health status of their patients.

In response to a question on reductions in medical services, 22 percent of the physicians reported that their hospitals had responded to the PPS by implementing programs to reduce the number of medical services provided to Medicare patients. Of these physicians, 40 percent reported that some of the reductions in medical services were in intensive care.

In addition to the collection of this type of survey data, the AMA is currently working with Johns Hopkins University to develop a series of research proposals that could result in a multifaceted study of the long term effects of the PPS on the quality of health care and Medicare beneficiaries. We are still seeking funding for this important project.

In conclusion, Mr. Chairman, in the interest of the elderly patients of this country, I am compelled to place squarely before this committee a growing concern among the Nation's physicians to treat Medicare patients. While physicians have been trained to be advocates for and protectors of their patients' health, physicians are increasingly being pushed into the uncomfortable and objectionable goal of being the advocate for and the protector of the Federal budget.

Physicians who are the side of patient advocacy are at a minimum, subject to challenge. At worse, they are subject to severe sanctions. Ultimately, it is the patient who suffers.

We hope that there will be a return to support by the Congress for strengthening the position advocacy role for the patient and the removal of the compromising climate that surrounds the patient care setting. If Congress continues to use Medicare as the primary focus of domestic budget savings, we could soon cross the point where cost concerns will dictate the availability of health and medical services.

[The prepared statement of Dr. Dawson follows:]

STATEMENT  
of the  
AMERICAN MEDICAL ASSOCIATION  
to the  
Select Committee on Aging  
United States House of Representatives

Presented by  
John H. Dawson, M.D.

RE: The Prospective Pricing System (PPS) -  
Discharge Status of Medicare Beneficiaries

April 10, 1986

Mr. Chairman and Members of the Committee:

My name is John H. Dawson, M.D., and I am a physician in the practice of general surgery in Seattle, Washington. I am also a member of the Board of Trustees of the American Medical Association. Accompanying me today is Bruce Blehart of the AMA's Department of Federal Legislation. We are pleased to have this opportunity to appear before you to share our concerns over the increasing reality of Medicare beneficiaries leaving our nation's hospitals while still in need of acute care. We have collected information on this trend through our DRG Monitoring Project and other activities.

The creation of the Medicare program in 1965 was a commitment to the elderly that this nation would assure them access to, and meet the major part of the cost of, high quality medical care services. To a large extent that promise has been met. The years since the enactment of Medicare have seen tremendous improvement in not only access to high quality health care but also in the health status of the covered population. One of the major reasons for this result has been the ability of the elderly to receive care in the same mainstream fashion as other individuals. We want these gains to continue.



The American Medical Association is deeply concerned about the impact of changes in the Medicare program on the ability of physicians and hospitals to assure the continued availability of high quality health care services for the Medicare population.

We are concerned in particular that the PPS may be a step back from the gains of the past twenty years. The combination of the incentives for not providing care that are inherent in the PPS and the fact that hospital reimbursement under this system routinely has been scaled back even prior to full implementation of the system points to increasing pressures to turn Medicare beneficiaries out of hospitals at a quicker rate with all of the attendant problems of earlier hospital discharges.

Since 1980, Medicare has been subjected to a continuing series of cuts and modifications that have caused considerable stress and anxiety over the ability of the Medicare program to meet the needs of its covered population. Each budget brings a new series of proposals to reduce Medicare expenditures, and this has been compounded even further by the addition of the Gramm-Rudman-Hollings reductions that are currently cutting back on Medicare reimbursements. There is an atmosphere of constant change and lack of stability in the Medicare program that is a serious threat for the 30 million program beneficiaries.

#### The AMA's DRG Monitoring Project

The American Medical Association initiated its DRG Monitoring Project in June 1984 to determine how PPS may affect the quality of patient care. The Association has sent letters to the chiefs of the medical staffs of over 6,000 hospitals asking them and their fellow physicians to share information with the AMA concerning their experiences, both positive and negative, which they feel are attributable to the PPS program. Announcements about the Monitoring Project have been sent to state medical and national medical specialty societies, and will be published again in AMNews and other Association publications. A solicitation aimed directly at the physicians in the hospital setting is scheduled to be published in the May 1986 issue of the AMA's Hospital Medical Staff Section Newsletter.

As of April 1, 1986, 435 written responses representing approximately 8050 physicians have been received. Comments were provided by physicians in almost every state, representing over 20 different medical specialties, teaching and nonteaching institutions, and urban and rural areas. A majority of the responses were received from chiefs of medical staffs who incorporated the comments of their entire medical staffs. Several chiefs of staffs conducted their own surveys and forwarded the

results to the DRG Monitoring Project. (The December 1985 Report on the DRG Monitoring Project and the Prospective Pricing System is attached to this statement as an appendix.) These responses can be summarized as follows:

- o Of the comments received concerning quality of care, 66% stated that the quality had deteriorated. Concerns have related to early discharges, limitations on laboratory tests and hospital stays in which a second patient condition or complication requires treatment.
- o Of the comments received concerning the cost of care, 85% reported that reimbursement in their hospitals was inadequate for one or more DRGs. Areas of concern continue to be that severity of illness is not appropriately accounted for in DRGs, small or rural hospitals are continuing to experience losses on DRGs, and reimbursement is inadequate for some DRGs.
- o Of the comments received regarding length of stay (LOS), 65% stated that LOS had decreased under PPS. An additional 25% questioned the appropriateness of LOS for certain DRGs.
- o Of the comments received concerning discharge policies, 43% reported that there was pressure to discharge patients early, and 32% reported that policies had changed for the better.
- o Of the comments received addressing administrative relations, 42% reported a deterioration in administration/physician relations, and 28% reported an improvement in such relations.

Mr. Chairman, the Monitoring Project helps to focus attention to the potential problem areas in the PPS. However, statistics pale in comparison with the actual statements we have received from physicians on how the PPS is affecting the care of their patients. The following are excerpts from submissions to the DRG Monitoring Project:

- o "A 91 year old was admitted because of partial intestinal obstruction due to colonic fecal impaction. He was vomiting, there was 1500 cc's of fluid in his stomach on nasogastric suction and his colon was filled with feces. His abdomen was distended and although he had been doing well with his 91 year old wife, his condition was considered very precarious and critical. As mentioned, he was treated with nasogastric suction and enemas. He improved, but by the time his DRG time was up, he was still weak, barely able to get out of bed, and certainly his 91 year old wife could not take care of him for several more days. However, our hospital insisted that he had to be moved out because of DRG problems."
- o "Our hospital has a good outpatient nursing care service, and we seem to have gotten by with sending patients home earlier without too much trouble, except for one of my recent patients. This was a 75-year old lady with chronic lymphatic leukemia, diabetes, and hypertension which is difficult to control, who unfortunately developed severe herpes zoster of the face and tongue and was unable to eat. We were pushed into sending her home. Despite visiting nurses, she did not eat and drink enough liquids and became dehydrated, and had to be re-admitted three days later. It would have been better for the patient had we just kept her in the hospital."
- o "As a practicing Urologist in a small community hospital, I find the patients, physicians and hospital personnel in great disarray, confusion and displeasure concerning the present administration of the DRG program.

The patients are treated callously and harassed by an attempt to expedite procedures in an attempt to perform early admission and discharge policies in the hospital. Patients complain bitterly about being forced out of the hospital long before they are feeling capable of caring for themselves. In addition, they are harried by short procedures that are carried out without

admission to the hospital which is severely discomforting to the patients. Also, early discharge creates a great medical concern from the physician's point of view.

I, as a physician, have found it very difficult to practice quality medical care in this environment of harassment, urgency and cutting short corners."

- o "[The PPS] has affected relations among administrators and physicians, since physicians are being told they cannot maintain patients in the hospital at a stay longer than what the hospital is able to afford even if the patient should still be in the hospital, but the hospital cannot afford this. It is creating stress between administrators and physicians and between physicians and utilization review physicians."
- o "There is no question that during the medical staff meetings, the administration is no longer concerned about the welfare of the patient. The only concern that we ever discuss in staff meetings, much to my objection, is the economics of the patients."
- o "This program is having definitely negative impact on health care delivery. We have hospital administration telling us to treat one medical problem at a time: clearly contrary to our training to treat the total health problems of the patient in the most efficient manner. We are under unsubtle pressure to cut days and utilization of services: clearly a compromise of our right to exercise our best medical judgment."

Already I am experiencing the distressing problem of pushing a patient out just a little earlier than I would like to, only to have them experience an exacerbation of difficulty requiring readmission."

- o "I think the handwriting is on the wall, however, that hospitals will keep "physician profiles" and from these may eventually determine that it is not profitable to keep certain physicians on the medical staffs."
- o "The DRG based reimbursement program is forcing patients early discharge from hospitals because of no-pay basis or reimbursement to that hospital and expenditures of thousands of dollars by that individual hospital. Laboratory studies which are directly or indirectly related to the patient's overall conditions cannot be ordered as an inpatient because that would bleed more rapidly DRG payments. One hospital will try to pawn off on another hospital a patient that has run out of DRG reimbursement. If they are out of DRG, a hospital will not accept transfers, will not accept readmissions, and as a result, poor medical care is being given."
- o "Our administrator has initiated a system of yellow and red stickers to be placed on the charts as the magic allotted figure nears consumption. It is very disconcerting to see these stickers on charts of patients who are critically ill and recently post-op. It's distressing that we are forced to live with a system that is so rigid that no allowance is made for complicating factors. The very idea that each disease can be standardized in each patient is preposterous."
- o "I have been taught (by the hospitals) to rearrange and make the diagnoses with the highest weights listed down first. This did not matter much before the DRGs. There is now more paperwork, time lost in reviewing the chart and cost in implementing and overseeing the program. Many of the small things that I never placed before the DRG times, I have to place them now amongst the diagnoses to increase the weight and multiplier. Thus to justify the stay!"

We are concerned that examples like these represent only the tip of an iceberg -- initial symptoms of what could prove to be a massive problem with the PPS. We are concerned that further squeezes on Medicare reimbursement will only increase these situations to the point where they are no longer isolated instances of system failure.

#### Future Studies on the Quality of Care in PPS Hospitals

The AMA will continue to monitor the effects of the PPS through the DRG Monitoring Project and through the use of surveys. As part of the Association's 1985 Socioeconomic Monitoring Survey of physicians, questions were posed relating to readmissions, early discharges, and reductions in medical services because of the PPS. The survey results are as follows:

- o Readmissions - Since the implementation of DRGs, 9.3 percent of the physicians stated that the average number of their Medicare patient readmissions had increased, while 6.8 percent of the physicians reported a decrease in readmissions. The remaining 83.9 percent of the physicians reported that the average number of their Medicare patient readmissions had not been affected.  
  
During their most recent complete month of practice, 34.6 percent of the physicians readmitted one or more Medicare patients for a complication or continuation of an illness, while 9.9 percent of the physicians readmitted five or more patients. The remaining 65.4 percent of the physicians did not readmit any of their Medicare patients for a complication or continuation of an illness.
- o Early Discharges - 40 percent of the physicians reported that they have discharged Medicare patients from hospitals earlier than they had before the implementation of DRGs. 59.6 percent of the physicians stated that they are discharging Medicare patients at the same time, while 0.4 percent of the physicians reported that their patients are being discharged later than before.  
Of the 40 percent of the physicians who stated that they have discharged Medicare patients from the hospital earlier under the DRG system, 39.2 percent of these physicians reported that the earlier discharges have worsened the health status of their patients, while only 0.5 percent of the physicians stated that their patients' health status improved due to the earlier discharges.
- o Reductions in Medical Services - 21.8 percent of the physicians reported that their hospitals had responded to the PPS by implementing programs to reduce the number of medical services provided to Medicare inpatients.  
  
Of the 21.8 percent of the physicians who reported that their hospitals had implemented such programs, 39.2 reported that some of the reductions in medical services were in intensive care usage.

In addition to the collection of this type of survey data, the AMA currently is working with Johns Hopkins University to develop a series of research proposals that could result in a multi-faceted study of the long-term effects of the PPS on the quality of health care for Medicare beneficiaries. The stated objective for this project is to "assess various impacts of the Medicare prospective payment system on the quality and utilization of health care using a variety of case mix methods." We are still seeking funding for this important project.

Conclusion

Mr. Chairman, the AMA is concerned about the potential for deterioration in the quality of health care available in this country. Our concerns are heightened by the fact that Medicare has been targeted for cuts, freezes and major program modifications in the budget process. We strongly believe that the Medicare program must be allowed to operate in a rational manner to assure the availability of a quality health care system for the growing numbers of elderly that our country is seeing and will see in the near future.

Mr. Chairman, in the interests of the elderly patients of this country, I am compelled to place squarely before this Committee a growing concern among the nation's physicians who treat Medicare patients. While physicians have been trained to be advocates for and protectors of their patients' health, physicians are increasingly being pushed into the uncomfortable and objectionable role of being the advocate for and the protector of the federal budget. Physicians who err on the side of patient advocacy are, at a minimum, subject to challenge; at worst, they are subject to severe sanctions.

This Committee has a long history of patient advocacy that is not being adequately reflected in initiatives of the Congress over the last several years. We hope there will be a return to support by the Congress for strengthening the physician advocacy role for the patient and remove the compromising climate that surrounds the patient care setting. If Congress continues to use Medicare as a primary focus of domestic budget savings, we could soon cross the point where cost concerns will dictate the availability of health and medical services.



## REPORT OF THE BOARD OF TRUSTEES

Report: R  
(I-85)

Subject: AMA's DRG Monitoring Project and  
the Prospective Pricing System

Presented by: William S. Hotchkiss, M.D., Chairman

Referred to: Reference Committee G  
(Ed L. Calhoon, M.D., Chairman)

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At the 1984 Interim Meeting, the House of Delegates adopted Board of Trustees Report FF which contained early responses to the AMA's DRG Monitoring Project. Report FF outlined not only major physician concerns, but also contained an update on the Prospective Pricing System (PPS), and identified some of the Association's activities in this area.

The following report is intended to provide the House of Delegates with an updated discussion of the impact of the PPS based upon responses received by the DRG Monitoring Project through August 31, 1985. A summary of the current status and changes in the PPS are also included.

#### CURRENT STATUS OF THE PPS

##### Hospitals Affected

All hospitals which were expected to operate under PPS are now doing so. This represents a total of 5,405 or 81 percent of all hospitals participating in the Medicare program. The remaining 1,246 or approximately 19 percent of the hospitals participating in Medicare are exempted from the PPS. These include:

- 555 Short-stay hospitals in waived states
- 464 Psychiatric hospitals
- 88 Long-term care hospitals
- 63 Rehabilitation hospitals
- 49 Children's hospitals
- 27 Alcohol/drug hospitals

In addition, 762 psychiatric units, 373 rehabilitation units and 314 alcohol/drug treatment units in acute care hospitals are currently exempted from the system.

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Past House Action: I-84:154-161; A-84:342,344,348; I-83:200-201;  
A-83:109-111,195-202,317-318; I-82:35-40,281;  
A-80:178-181

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### Hospital Admissions

According to the August 1985 Health Care Financing Administration (HCFA) Background Paper, there were approximately 6.5 million Medicare short-stay hospital admissions from October 1, 1984 through April 30, 1985. This represents a decrease of 5.4 percent for the same period in fiscal year (FY) 1984.

The Professional Standards Review Organizations (PSROs) and the Peer Review Organizations (PROs) have continued to examine a percentage of Medicare Hospital admissions and discharges. As of May 31, 1985, 32 percent of all PPS admissions have been reviewed, resulting in the denial of payment of 2.6 percent of the reviewed admissions. In FY 1984, 32 percent of all PPS admissions were also reviewed. Payment was denied for 2.8 percent of those reviewed admissions.

### Length of Stay

From October 1, 1984, through April 30, 1985, the average length of stay (LOS) for Medicare patients in PPS short-stay hospitals was 7.7 days, which is slightly higher than the 7.6 days for the same period in FY 1984. The average LOS for Medicare patients in all short-stay hospitals, including exempted hospitals, was 9.0 days in FY 1984. In addition, HCFA notes that comparisons between FY 1984 and FY 1985 are difficult because of the geographic variation of PPS phase-in during FY 1984 and a lack of a complete year's worth of data in FY 1985.

### Ten Most Common DRGs

Table 1 presents the ten most common diagnosis related groupings into which discharges have been classified through July 28, 1985, as reported by HCFA. These "top ten" DRGs have accounted for 29 percent of all PPS discharges during the current fiscal year. As can be noted in Table 1, there is a year-to-year fluctuation in DRG ranks. For example, while DRG 96 (Bronchitis and Asthma) moved from twelfth place in FY 1984 to sixth place in FY 1985, DRG 39 (Lens Procedures) dropped from third place in FY 1984 to eleventh place in FY 1985.

### CHANGES IN THE PPS

HCFA has continued to receive recommendations for PPS modifications from the AMA and other health care organizations. Based on these recommendations and due to experiences with the system, HCFA was expected to implement the following changes, effective October 1, 1985.

### Payment Rates

In analyzing the combined effect of the forecasted increase in the hospital market basket, the proposed composite factor, and the proposed composite policy target adjustment factor, HCFA concluded that the FY 1986

payment level should be 4.42% below the existing payment level. However, in its scheduled PPS rule change, HCFA will set the FY 1986 standardized payment rates at the same level as the FY 1985 payment rates.

#### Hospitals Affected

The states of Massachusetts and New York will not seek renewal of their waivers which currently exclude them from the Medicare PPS. Effective October 1, 1985, Massachusetts will be included in the PPS, as will New York, effective January 1, 1986.

TABLE 1  
PROSPECTIVE PAYMENT SYSTEM MONITORING  
TEN MOST COMMON DRGs  
October 1, 1984 through July 28, 1985

| <u>FY85 Rank</u> | <u>FY84 Rank</u> | <u>DRG No.</u> | <u>Description</u>                                      | <u>Discharges</u> | <u>Percent of Discharges</u> |
|------------------|------------------|----------------|---------------------------------------------------------|-------------------|------------------------------|
| 1                | 1                | 127            | Heart Failure and Shock                                 | 210,720           | 5.2                          |
| 2                | 6                | 089            | Simple Pneumonia and Pleurisy                           | 163,987           | 4.1                          |
| 3                | 5                | 140            | Angina Pectoris                                         | 134,623           | 3.3                          |
| 4                | 2                | 182            | Esophagitis, Gastroenteritis, Misc. Digestive Disorders | 133,011           | 3.3                          |
| 5                | 4                | 014            | Specific Cerebrovascular Disorders                      | 126,148           | 3.1                          |
| 6                | 12               | 096            | Bronchitis and Asthma                                   | 89,829            | 2.2                          |
| 7                | 8                | 138            | Cardiac Arrhythmia & Conduction Disorders               | 85,769            | 2.1                          |
| 8                | 10               | 296            | Nutritional and Misc. Metabolic Disorders               | 81,887            | 2.0                          |
| 9                | 9                | 088            | Chronic Obstructive Pulmonary Disease                   | 74,910            | 1.9                          |
| 10               | 7                | 243            | Medical Back Problems                                   | 71,866            | 1.8                          |

SOURCE: Health Care Financing Administration

#### DRG Reclassifications

HCFA was expected to implement the following DRG changes effective October 1, 1985:

- Bilateral Joint Procedures - In the first DRG Monitoring Project Report, the Board of Trustees reported that many physicians were concerned with inadequate reimbursement for bilateral knee and hip replacements which were classified under DRG 209 (Major Joint Procedures). HCFA has created

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DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) to encompass certain combinations of major joint procedures within DRG 209 that may be performed during the same hospital stay. Any bilateral knee and/or hip replacements that are performed during the same hospital stay will now be assigned to DRG 471. In general, payments for these procedures will be increased under DRG 471.

- Kidney Transplants for Diabetic Patients - Diabetic patients with end stage renal disease (ESRD) who receive kidney transplants are currently classified into DRG 468 (Unrelated O.R. Procedures). However, according to HCFA, since these patients required the clinical services and resources described for DRG 302 (Kidney Transplant), diabetic ESRD patients who receive kidney transplants will now be classified into DRG 302. In general, payments for kidney transplants will be increased under this reclassification.
- Alcohol and Drug Abuse DRGs - According to HCFA, the content and relative weights of DRGs 433-437 have been revised and recalibrated to accurately account for resources utilized in these DRGs. HCFA believes that these DRGs will provide a better means of distinguishing the cases in which substance abuse results in hospitalization and cases in which substance abuse requires both detoxification and rehabilitation care. The substance abuse cases will now be classified into the following DRGs:

-DRG 433 - Substance Use and Substance  
Induced Organic Medical Disorders, Left  
Against Medical Advice.

-DRG 434 - Substance Abuse,  
Intoxication, or Induced Mental Syndrome  
Except Dependence.

-DRG 435 - Substance Dependence,  
Detoxification and/or other Symptomatic  
Treatment.

-DRG 436 - Substance Dependence,  
Rehabilitation Therapy.

-DRG 437 - Substance Dependence,  
Combined Rehabilitation and  
Detoxification Therapy.

At this time, any changes in payments under revised DRGs 433-437 cannot be estimated.

### Recalibration of DRG Weights

The DRG relative weights currently used by the PPS are based on 1981 hospital operating cost information and data. For FY 1986, HCFA has recalibrated the DRG weights utilizing actual charge data set forth in the FY 1984 data set. Besides being more recent, this data was derived from 100 percent of FY 1984 Medicare hospital discharges, compared to the FY 1981 data which consisted of a 20 percent sample of Part A inpatient hospital bills.

In addition, many physicians have raised concerns that reimbursement payments are not adequate for cardiac pacemaker implantations (DRGs 115-118), intraocular lens procedures (DRG 39), and infective endocarditis (DRG 126). While HCFA has not selectively revised these DRGs, they have recalibrated the relative weights based on the FY 1984 data. Except for DRG 117, the relative weights for all the above DRGs will increase in FY 1986.

### Outliers

The PPS has continued to authorize additional payments for atypical or "outlier" cases, which are defined as cases involving an unusually long length of stay (day outlier) or cases in which the costs are substantially above the DRG rate (cost outlier). Scheduled HCFA modifications for all DRGs include increasing the threshold for cost outliers from \$13,000 to \$13,500 and decreasing the length of stay outlier criteria from 22 to 17 days.

## DRG MONITORING PROJECT

### Purpose

The AMA's DRG Monitoring Project was designed as an information assessment activity to elicit reactions and comments from physicians on the impact of the PPS in their hospitals, and to identify "problem" areas that may necessitate further study. The information obtained from the project has been, and continues to be, instrumental in developing congressional testimony, formulating policy and seeking modifications in the PPS, and providing input into scientific studies.

### Implementation

The DRG Monitoring Project was implemented in June 1984. During the past 16 months, the AMA has elicited physician responses through letters written to the chiefs of medical staffs in all U.S. hospitals on the PPS, and through advertisements in AM News and JAMA. Several state medical associations, national medical specialty societies, and hospital medical staffs have also promoted the project through their newsletters.



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1 Status

2  
3 As of August 31, 1985, 389 written responses representing  
4 approximately 7800 physicians have been received by the AMA. Comments  
5 were provided by physicians in 40 states, 20 different medical  
6 specialties, teaching and nonteaching institutions, and urban and rural  
7 areas. A majority of the responses were received from chiefs of medical  
8 staffs who incorporated the comments of their entire medical staffs.  
9 Several chiefs of staffs conducted their own surveys and forwarded the  
10 results to the DRG Monitoring Project.

11  
12 The majority of responses presented views on several issues and a  
13 number contained detailed supporting documentation. The areas of most  
14 common concern were:

- 15  
16 • Quality of care  
17 • Costs of care  
18 • Length of stay  
19 • Admission/discharge policies  
20 • Administrative relations  
21

22 A summary of these categories is presented below.

23  
24 Quality of Care

25  
26 Of the comments received concerning quality of care, 66 percent  
27 stated that the quality had deteriorated, while 34 percent stated that  
28 the quality had either improved or remained the same.

29  
30 One major concern encountered by many physicians involves hospital  
31 stays in which a second patient condition or complication also requires  
32 treatment. Some physicians reported that they have been discouraged from  
33 providing immediate treatment for a second condition, because the  
34 hospital may not receive additional reimbursement for a second procedure.

35  
36 Some physicians also expressed concerns over the effect that early  
37 discharges may have on the health care of patients. Many physicians face  
38 the dilemma of either prolonging their patients' length of stay, or  
39 discharging them to alternative health care facilities. According to one  
40 respondent:

41  
42 "a number of patients we have had have been forced in a  
43 certain respect to go into (an alternative health care  
44 facility) from the hospital because they have not been able  
45 to go home yet and should have remained in the hospital,  
46 but could not because of marked overextension of their  
47 health care costs. I do feel some of these patients are  
48 receiving a lesser quality of care than other patients."

49  
50 Another concern involved administrative "pressure" to place limi-  
51 tations on laboratory tests and procedures. Many physicians reported  
52 that quality of care may be affected by a decrease in the use of

laboratory tests necessary for proper diagnosis. In the words of one respondent:

"Eventually the quality issue will focus on underutilization of the necessities of care by all providers (physicians and hospitals) versus the overutilization of the past."

#### Cost of Care

Of the comments received regarding the cost of care, 85 percent reported that reimbursement to their hospitals was inadequate for one or more DRGs. Fifteen percent of the comments stated that either the hospital has not lost money through DRG reimbursement, or the hospital was able to bring costs in line with reimbursement. Major areas of concern continue to be that: (1) severity of illness is not appropriately accounted for in DRGs; (2) small or rural hospitals are continuing to experience losses on DRGs; (3) bilateral hip and knee replacements have the same reimbursement as unilateral procedures; and (4) reimbursement is inadequate for cardiac pacemakers, lens procedures, and treatment for infective endocarditis.

#### Length of Stay

Of the comments received regarding length of stay (LOS), 65 percent of the respondents stated that LOS had decreased under the PPS, while 10 percent said that there had been no change in LOS. The remaining 25 percent of the respondents did not acknowledge a change in LOS, but questioned the appropriateness of LOS for certain DRGs. Some of these include:

- DRG 8 (Surgery on Cranial Nerves, over age 70 - mean LOS of 4.1 days)
- DRG 11 (Nervous System Neoplasms, under age 70 - mean LOS of 8.5 days)
- DRG 29 (Traumatic Stupor plus Coma, one-hour - mean LOS of 3.8 days)

#### Admission/Discharge Policies

Of the comments received concerning admission and discharge policies, 43 percent reported that there was pressure to discharge patients early, 32 percent stated that policies had changed for the better, and the remaining 25 percent stated that they have not noticed a change in hospital discharge policies.

The presumed reason behind early discharges involves keeping the LOS at the mean LOS for most DRGs, thus enabling the hospital to maintain "break even" reimbursement. While some physicians have reported

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favorable influences by emphasizing preadmission testing and discharges to home care, others have questioned the quality of care when patients are discharged early to alternative health care facilities.

#### Administrative Relations

Of the letters received addressing administrative relations, 42 percent reported a deterioration in administration-physician relations, 30 percent reported no change, and 28 percent reported an improvement in relations. The negative comments related to administrative "pressures" to shorten LOS through early discharges; to delay treatment of secondary conditions or complications; to decrease the utilization of some laboratory tests; and to perform some procedures on an outpatient basis regardless of patient age and mobility. The positive comments related administrative efforts to develop medical education programs and literature on DRGs; to provide physicians with cost of treatment records comparing individual averages to medical staff averages; and to develop DRG committees comprised of physicians, administrators and ancillary hospital personnel.

#### Summary of Key Findings

The DRG Monitoring Project has continued to receive both positive and negative comments regarding the impact of the PPS on patients, hospitals and physicians. The areas which respondents identified as requiring further study include:

- The concern for deteriorating quality of care due to early discharges, limitations on laboratory tests, and hospital stays in which a second patient condition or complication requires treatment.
- The failure of DRGs to account for the severity of illness of individual patients.
- The continued financial risks faced by small and rural hospitals.
- The average LOS continues to be questioned for specific DRGs, such as traumatic stupor plus coma, surgery on cranial nerves, and nervous system neoplasms.

Positive comments have noted some instances in which costs have been cut and quality of care retained through the use of outpatient treatment, preadmission testing and discharges to home health care. Other comments have reported a positive effect that the PPS has had on improving communication between administrators and physicians.

## 1 FUTURE ACTIVITIES BASED ON THE DRG MONITORING PROJECT

2  
3 The DRG Monitoring Project will be an ongoing activity throughout  
4 the final year of the PPS phase-in. The Board of Trustees urges  
5 physicians to continue to report their experiences to the following  
6 address:

7  
8 AMA's DRG Monitoring Project  
9 Department of Health Care Resources  
10 P.O. Box 10947  
11 Chicago, Illinois 60610  
12

13 The information will be used to:

- 14  
15 • Identify the particular problem areas which have been, and  
16 will continue to be, forwarded to HCFA, utilized in  
17 congressional testimony, etc.  
18  
19 • Provide background information for a proposed joint  
20 AMA-Johns Hopkins University study of the long-term effects  
21 of the PPS on the quality of health care for Medicare  
22 beneficiaries.  
23  
24 • Aid in the continued development of policy initiatives and  
25 programs for physicians and patients.  
26

27 The Board of Trustees will report to the House of Delegates on future  
28 DRG Monitoring Project findings.

The CHAIRMAN. Thank you, Dr. Dawson. The Chair now recognizes our final witness, Mr. Robert Stutz, who represents the American Hospital Association. Would you please proceed in any manner you may desire.

**STATEMENT OF ROBERT V. STUTZ, REPRESENTATIVE, AMERICAN HOSPITAL ASSOCIATION; AND VICE PRESIDENT, ALBERT EINSTEIN MEDICAL CENTER, PHILADELPHIA, PA**

Mr. STUTZ. Mr. Chairman, I am Robert Stutz, vice president of the Albert Einstein Medical Center in Philadelphia, PA. I am here on behalf of the American Hospital Association, which represents 6,300 hospitals and other health care institutions; and the general director of the Willowcrest-Bamberger Division, which is a short-stay, hospital-based skilled nursing facility.

I would like to address my comments to two areas. First, I will discuss the problems affecting my institution in particular, as an example of the difficulty facing health care institutions in general; and, second, the impact of the Medicare budget crisis. I commend Representative Roybal and members of the committee for its sensitivity to issues affecting the elderly in the new health care system of the 1980s. I want to assure you that there need not be a no-care zone. Our experience with reductions in post-hospital care began a year-and-a-half ago, just prior to the implementation of the prospective payment system. With the new system, it was certainly recognized that post-hospital care would become a more important element in the continuum of care. However, it appears as if HCFA has chosen a course of action that would drastically restrict access to skilled nursing facility, post-hospital care.

Through HCFA directives, two unprecedented actions had been undertaken. The first was the implementation of 100 percent chart review by fiscal intermediaries of all patients transferred from the acute care setting to a hospital-based skilled nursing facility. HCFA claims that this action was to assure that patients were not prematurely discharged from the acute care setting. In reality, this review has been used as an adversarial tactic to deny patients thousands of skilled care days under the pretext of the new stringent HCFA interpretation of Medicare criteria. The rate of denied days grew from zero to over 76 percent in late 1984 and into 1985 at our 102-bed skilled nursing facility. This translates into a fiscal loss of over \$1 million in fiscal year 1985 and a closing of 50 post-hospital skilled nursing beds. But more importantly, access to needed care was denied to hundreds of patients who we felt met Medicare criteria and in the past were eligible for skilled care.

The second method used by HCFA to discourage use of post-hospital Medicare services has been to eliminate the waiver of liability, which I know now has been put back into effect. But we asked the committee to diligently oversee the implementation and the use of this waiver benefit by HCFA. I was told this very morning by a congressional source, that although the waiver is back in place, the project group in HCFA that administers this benefit is still under the same marching orders to make sure the waiver means little or nothing.



The bottom line is that thousands of patients who could benefit from a less costly post-hospital stay are denied their benefits. This benefit is fraught with inconsistent interpretation. The outcome of a case review varies with each HCFA region and intermediary. Providers and beneficiaries are given no specific reason when coverage is denied. This policy helps compound inconsistencies in interpretation and makes it difficult to determine who is eligible for admission to a skilled nursing facility.

Let me take a moment to describe some interpretation problems that we are experiencing in our facility in interpreting HCFA policy.

In our region, HCFA has determined that transferring, a very important physical therapy service, is no longer considered a skilled care. Transferring is teaching a patient how to get from the bed into a chair. This skill alone makes the difference between living in a long-term care setting or returning to one's home and community. HCFA has decided that the teaching of transferring is not a justifiable physical therapy service. Even when there are other complicating medical factors that are reimbursable, the physical therapy portion of the skilled stay will be denied.

A second service we have traditionally provided has been to admit debilitated patients undergoing a course of radiation therapy in our adjacent hospital—such as your husband. Medicare has refused payment for frail elderly cancer patients who are undergoing radiation therapy. The administration decided that this service should be provided on an outpatient basis. The result is that these patients must take exhausting and life-threatening ambulance rides twice daily. We are also told that the Medicare skilled benefit is to be applied with absolutely no regard to social circumstances or support services available in the patient's home.

I would like to offer a basis of improving access to post-hospital care. First, the Medicare skilled nursing criteria needs to be rewritten so they are consistent with the new prospective payment system. Criteria should be specific and administered consistently. Perhaps Peer Review Organizations could provide continuity and consistency of judgment as patients move between the acute care hospital and the skilled nursing facility.

Second, in an effort to increase the number of providers that would offer short-term post-hospital care, patients should be pre-certified by the PRO. This minimum pre-certification period could allow the patient and the provider a guaranteed secure benefit. And I know you have introduced that policy in a bill.

I would also recommend a change in the appeals process. Providers must be allowed to use the appeals process without the involvement of the beneficiary. This is necessary since it is only the provider who is at financial risk after admission. Furthermore, many elderly beneficiaries are medically unable to assist in the lengthy appeals process. In addition, court rulings should be precedential.

A recent patient placement survey performed by the Delaware Valley Hospital Council, located in Philadelphia, documents continued problems hospitals are experiencing placing patients in facilities providing subacute skilled care. This survey estimated a loss exceeding \$23 million to southeastern Pennsylvania hospitals provided skilled subacute care to patients awaiting transfers

to post-hospital care facilities. In addition, this money could be better spent on behalf of Medicare beneficiaries.

I would like to take a moment to talk about Medicare budget cuts.

Since 1981, the Medicare Program has been cut by \$40 billion. This constitutes 12 percent of all budget cuts, even though the Medicare Program represents only 7 percent of Federal outlays. The President's fiscal year 1987 budget called for a Medicare reduction of \$5.2 billion and Medicare cuts of \$1.2 billion. Since 1981, defense spending has increased from 22 percent to 26.3 percent of Federal outlays while Medicare has declined from 7.6 percent to 7.1 percent of outlays. We believe that health programs should be treated equitably relative to other budget categories.

In addition, if Congress and the President are unable to agree on a plan to reduce the deficit to the \$144 billion required by Gramm-Rudman-Hollings, Medicare payments to hospitals will be reduced automatically by 2 percent, effective October 1, 1986. This would amount to a reduction of 3 percent below the funding year 1985 level of payment.

The major restructuring of the Medicare Program under prospective payment has resulted in substantial changes in the health care system. With the establishment of this new approach to more cost-effective health care, attention must now focus on maintaining the quality of that care.

A recent study prepared by the Hospital Research Foundation of the Hospital Association of Pennsylvania examined utilization patterns in Pennsylvania hospitals over a 3-year period. The study is based on an analysis of 4.2 million discharges from the State's community hospitals between July 1982 and June 1985. It compares the 2 years preceding PPS to the State's first year under this system. The study found that changes in hospital utilization patterns are for all patients, not just for Medicare patients. The average length of stay dropped from 7.7 days in 1983 to 6.6 days in 1985, a decrease of 14.3 percent. Medicare patients exhibited the most significant decline in length of stay, from 11.1 to 8.8 days, a 20.7 percent decrease. Readmissions decreased 23 percent, the readmissions within 14 days or up. The increase of readmissions applied to all payers.

In addition, the study found that the average length of a hospital stay decreased for all payment categories. Transfers from the original transferring hospital to another type of provider increased. Patient acuity levels differed among transfer sites. Five transfer sites, organized home care, psychiatric facilities, intermediate care facilities, custodial care and others, experienced increases in the numbers of transfers during this 3-year period.

In conclusion, the implementation of Medicare's prospective payment system has provided a unique opportunity for examining the objectives of cost containment, quality of care, and access to services. If the system is manipulated simply to produce short-term budget savings, the result will be a reduced ability by hospitals to provide services to the elderly. A successful Medicare system requires payments that are adequate and equitable. Only then will the program be able to meet its objectives of containing costs with-

out adversely affecting delivery of high quality services to the Medicare population.

Thank you.

[Additional material submitted by Mr. Stutz follows:]

American Hospital Association

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 Suite 500  
 Washington D.C. 20001  
 Telephone 202 638-1100  
 Cable Address: Amerhosp

ADDENDUM  
 TO  
 TESTIMONY OF ROBERT V. STUTZ  
 on behalf of the  
 AMERICAN HOSPITAL ASSOCIATION

APRIL 10, 1986

The American Hospital Association is concerned with the disproportionate cuts that the Medicare program has faced since 1981. Medicare cuts since 1981 have equalled 12 percent of all budget cuts even though Medicare represents only 7 percent of federal outlays.

The attached information on health and the budget summarizes the impact of Medicare spending cuts over the last several years.

### Health and the Budget

#### Health Cuts - Disproportionate

- o Medicare cuts since 1981 - nearly \$40 billion over 100,000 jobs eliminated
- o Medicare cuts since 1981 have equalled 12% of all budget cuts even though Medicare represents only 7% of federal outlays
- o President FY 1987 Budget calls for a Medicare reduction of \$5.2 billion and Medicaid cuts of \$1.2 billion totalling \$6.4 out of \$38 billion in total budget cuts (14%).
- o Since 1981 Defense spending has increased from 22% to 26.3% of federal outlays while Medicare has declined from 7.6% to 7.1% of outlays.

#### Impact of Health Cuts on Quality and Access

- o Medicare population growing by 20% in next decade -- the over age 85 population will grow 50%
- o Impact on quality and access obvious if more people are served with same amount of funding
- o Cuts in labor, staffing, wage increase, inventories, length of stay have already been made by providers, there is no more fat or waste to cut. These reductions cannot continue without adverse impact on quality.
- o Further cuts will force reductions in medical progress, research, education, replacing obsolete equipment, postponing modernization, delaying new services or dropping needed services.
- o Medicaid cuts are aggravating the indigent care problem. Access to health services for the poor is being narrowed by low income Medicaid eligibility standards in many states and inability to cross subsidize indigent patients through higher charges to privately insured patients.



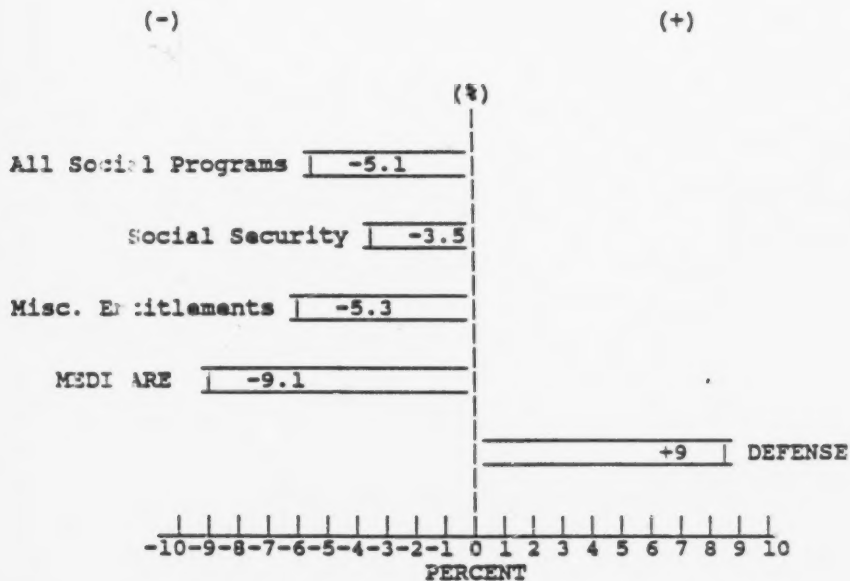
Health Costs

- o 1984 lowest rates of increase in 20 years
- o Percent of GNP devoted to health has actually declined (10.6%)
- o Medicare Trust Fund headed for 1985 bankruptcy now solvent for nearly 20 additional years
- o The total number of hospital beds has dropped
- o Admissions have been reduced
- o Length of stay has dropped
- o Physicians using more outpatient settings where medically appropriate

Recommendations

- o Health programs should be treated equitably relative to other budget categories.
- o Defense cuts and revenue enhancements must be part of the deficit reduction process.
- o If less money for defense weakens our national security, then less money for health weakens our commitment to access to quality health care.

## CUTS AS A PERCENT OF PROGRAM OUTLAYS \*, 1982-1987



\*Cuts shown are the result of legislation enacted since 1981 and assume acceptance of the president's budget for FY 1987.

The CHAIRMAN. Thank you, Mr. Stutz.

I would like to ask some questions of the three witnesses. But before we start, Mrs. Seeley, I would like to ask some questions about that beautiful gavel you have before you. Tell me something about it.

Mrs. SEELEY. This is the thing that he does. He makes gavels. He makes beautiful bird houses. He teaches our elderly seniors in one of our senior centers in Milwaukee. And he just loves his job. He is a retired woodshop teacher after being a carpenter all his life. At 55, he went in and taught high school as a tradesman. He retired from there when he was 67 years old. He makes these gavels. And I thought it would be nice if we gave one to you. But I am sure sorry that the engraver isn't as good as my husband. He has some mistakes on it. But, Mr. Roybal, I am going to take it back home. I'm going to get the plate fixed, and I'm going to give it back, and they are going to present it to you. I don't want to give it—"select," he spelled "select" with two "l's;" "Committee on Age" and not "Aging." I said, "Jack, how could you do that?" He said, "Oh, God. They probably won't notice it." I said, "Yes, they will."

The CHAIRMAN. Well, I thank you very much. I wish to express my appreciation and that of the committee. When that does return, we will make that the official gavel of this committee as long as I am chairman.

Mrs. SEELEY. I certainly hope so. Thank you very much. My husband will be proud of it.

The CHAIRMAN. Thank you.

And I would like to ask you one question. It is quite a broad question. I greatly appreciate your testimony. I believe I know how hard it was for you to give it. But what, in your mind, should we do to make sure that no other person goes through what you and your husband have experienced? What can be done? What can we as a Congress or we as a nation do? What can be done?

Mrs. SEELEY. You have to teach our seniors when they go into the hospital, ask questions.

I haven't seen this report. I just put him back in Monday. I met a new doctor yesterday morning who was checking his lungs. And he said, "Oh, I just read in our American Medical Brochure that you have——" and I said, "Yes, doc, you have 48 hours. I knew that before." I have not seen anything about it, that he had the right to appeal. If I had known that, when I said to that doctor he is not ready to go home, and he said, "I know it, you know it, but he has to go," I could have appealed. But I did not know anything about it.

The CHAIRMAN. Well, did anyone explain to you about your husband's rights to service or his right to appeal under Medicare?

Mrs. SEELEY. No.

The CHAIRMAN. No explanation was given by anyone?

Mrs. SEELEY. No. Even Monday when I had to readmit him, nobody said anything about his rights. I shook my fist at the doctor yesterday and I said, "You better take good——" he said, "We're going to take good care of him while you're gone." They knew I was leaving. And I said, "You better not release him until he is well." He said, "We won't."

The CHAIRMAN. Well, that would help in the long run having some very direct communications between the patient and the doctor on this particular matter.

Mrs. SEELEY. Might I suggest that maybe they ought to do like in a hotel. You get out at such a time, put it in the—where the family can read their rights. We all have families. The poor souls who don't have any families, I feel sorry for them. And I visit many nursing homes in many senior centers, and they hold my hand and they beg me, please help.

We ask Congress to listen to us. We are having problems to make changes to protect us, and we cannot wait for fancy studies. We are beyond that. It is too late.

The CHAIRMAN. Well, I agree. I think we have enough studies. We need some action now.

Mrs. SEELEY. You better well know it. And fast. A lot of action.

I know the doctors are upset. They came in my room when he was there 5½ weeks. They know my position in Wisconsin and they are upset about the whole affair. They are upset about the DRG's. And it is the hospital administrators that are putting the pressure on the doctors. They are not happy about it.

The CHAIRMAN. Is it your contention, then, that it is the hospital that is primarily responsible for the early discharge?

Mrs. SEELEY. In my husband's case, I would say yes. When he says I have to put on a different hat now, the hospital said he had to go.

The CHAIRMAN. Well, from some of the testimony we have heard, that appears to be the case. However, the doctor should be and is in full control most of the time of his patient's welfare.

I will be asking Dr. Dawson how that conflict arises and what difficulty the physician has in making that decision. I won't ask you; I'll ask him because he is probably the one that has faced that most often.

Dr. Dawson, will you tell us that?

Dr. DAWSON. Yes; I will try, Mr. Chairman.

I happen to come from a section of the country which has the shortest length of stay, I believe, in the United States, and we have not run into the problem as frequently as has been reported elsewhere, in my personal experience.

I believe there is a great deal of confusion as to just what the rules are, both in the minds of the doctors and in the minds of some hospital administrators. When this massive program was started, there was concern that we were launching a monster-ship and we did not know how it was going to float or where it was going to sail. But the end result has been a lot of midcourse corrections, a term that was used earlier today; new requirements that came out. And concerns over just what the rules are, concerns about the implementation of the PRO's, and all the rest. The physicians and hospitals have had a love-hate relationship, not too dissimilar from some marriages, I suppose, through the years. And they do not want to see the hospitals which were—some of which were—predicted to fail under this system, they do not want to see them fail. And when the hospital committees, under the pressure from administrators, have said we've got to get our patients out

sooner, then they try to do a good job and try to go along with that which will keep the hospital healthy.

In the specific instances such as Mrs. Seeley has alluded to, the physician does not feel that he wants to do it. But I'm not certain that doctor really knew he had the right to keep her husband in.

And I think there is misunderstanding, misinformation that is out there.

The CHAIRMAN. What effect do you think another freeze in hospital and physician payments will have on the quality of care provided to Medicare beneficiaries and their access to post-hospital care.

Dr. DAWSON. I believe that the quality of care will not be diminished. The physicians will deliver the care that they know how to deliver, and they will do it the best way they possibly can. My concern is that it may diminish the access. The physician who has, if he feels, too many Medicare patients and that his income may get down to where his overhead makes it such that it really is not advisable for him to take care of Medicare patients, he may stop seeing Medicare patients.

The CHAIRMAN. Well, Doctor, are all hospitals in the United States operating at 100 percent capacity?

Dr. DAWSON. No; they are not. Many of them are not.

The CHAIRMAN. There must be a tremendous vacancy factor in a lot of hospitals in the country.

Dr. DAWSON. That is true.

The CHAIRMAN. What happens if a hospital operates at, say, 60 percent capacity; does that mean that 40 percent of their nurses remain idle, or do they keep—

Dr. DAWSON. Or they close wards and lay off personnel. That is a very common method.

The CHAIRMAN. So the ultimate goal, then, is to reduce the number of personnel, but not necessarily to reduce the quality of care?

Dr. DAWSON. Yes. That is correct. They try to maintain the quality of care.

The CHAIRMAN. So your contention is that if another freeze comes about, that the quality of care would not suffer?

Dr. DAWSON. It is my opinion that that is correct; that the quality of care delivered both by the physician and that which will be attempted to be delivered by the hospital, they will attempt to do the same and have it high quality. They may choose to close an intensive care unit or a coronary care unit, and thus reduce the quality in that way.

The CHAIRMAN. How in your mind might the process of hospital discharge planning be improved to avoid the problem of premature discharge and allow a smoother transition to post-hospital care?

Dr. DAWSON. I think better dissemination of the rules would be a great help, both through the hospital and through the medical associations, so that the doctors and the hospitals all know what the rules are; and to incorporate the discharge planners much earlier to find out what the home support system—

The CHAIRMAN. It seems to me that it is an absence of complete knowledge of rules that seems to prevail in most instances. Is that a correct assumption?



Dr. DAWSON. I am sure that is correct in many instances, that there is lack of knowledge of the rules. As we get more experienced with the program, we will all come to understand them better.

The CHAIRMAN. Now, Mr. Stutz, in your formal statement, you say that "there need not be a 'no care zone'." Do you think that there is one now?

Mr. STUTZ. A growing one. I think a lot of the services that were there and in place that might have complemented the prospective payment system are slowly being withdrawn, not unlike mental health a number of years ago.

The CHAIRMAN. I am going to ask you the same question, using other terminology, that I asked the doctor.

What effect do you think further reductions in hospital and other provider payments will have on quality care?

Mr. STUTZ. Let me answer that in terms of my own hospital. And I want to say one other thing. And that is that I know in the Philadelphia area, and particularly in my own hospitals, I know of no instance where a physician does not make the ultimate discharge decision. I think in our case, an administrator would be hard put to remove someone or discharge someone from a hospital without a physician's compliance.

It is true that hospitals are struggling financially, and there is certainly some pressure to not keep people unnecessarily in hospitals. We are hearing stories that there are cases where that happens.

In my own hospital, we are struggling with a budget cut this year of some \$19 million. Certainly, it is going to impact on not only the quality, I think, but it will impact on who we can serve. Our hospital has given some \$7 to \$8 million yearly of free care. We certainly have to take a look at that as the DRG system unfolds.

So I cannot sit here and say that there is not an impact. There certainly is.

The CHAIRMAN. Mr. Wise.

Mr. WISE. Thank you, Mr. Chairman.

Mrs. Seeley, we thank you very much for the time and the sacrifice that you made to come here.

And as we have been talking about the appeals notice, I just wondered—your husband is in the hospital now, I think, is he not?

Mrs. SEELEY. Yes, he is.

Mr. WISE. Did he receive the appeals notice, or did you receive this when you went in? This is what the gentleman from HCFA gave us called "An Important Message from Medicare," that talks about your appeal rights.

Mrs. SEELEY. No, I have received nothing.

Mr. WISE. Even with the admissions that have occurred since January 7 or 8?

Mrs. SEELEY. Nothing.

Mr. WISE. Thank you.

Mr. Stutz, I came away from the HCFA presentation with the assumption that this was now standard form in all hospitals and was distributed to all patients. Is that the case in your understanding?

Mr. STUTZ. I believe it has just begun. It is a new procedure.

VOICE: As of March 24.

Mr. STUTZ. Right. Another letter has been changed, I believe.

Mr. WISE. Then turning to Dr. Dawson, following up on Chairman Roybal's questions about education, is the American Medical Association undertaking any kind of program to educate its members better as to what their specific rights are in this situation?

Dr. DAWSON. We have not used a formal educational mechanism, but we have put in AM News, our newspaper that goes out weekly, and in a green-head that goes out as an informative letter the changes that occur. But as to the specifics of that which we have been talking about, we have not formalized an educational program as yet.

Mr. BLEHART. Also, fairly recently, the AMA developed its Hospital Medical Staff Section, and that has a regular newsletter which goes out and is used to bring these sorts of issues directly to the physicians who work in the hospital setting.

Mr. WISE. I see.

Well, I have participated some with the American Bar Association, and I got reams of material on different subjects, from the trial lawyers' section, the wills' section, probate section, and domestic relations. Sometimes I did not get through it as quickly as I ought to. So I just wonder if possibly you might consider undertaking some kind of direct communication. It seems to me this is going to be a much more important issue in the days to come.

Dr. DAWSON. I agree with you. I think that is an excellent suggestion. I believe that we will do that. They keep changing the rules on us.

Mr. WISE. Yes; we notice.

It seems to me also, both Dr. Dawson or Mrs. Seeley and Mr. Stutz, that there is this inherent conflict sometimes between physician and administrator.

Let me ask you a hypothetical question of—Dr. Dawson, I will ask you to respond first—whether in areas such as rural areas—I represent basically a rural area—where you have one medical center, or in an area where the medical center is a dominant facility and all doctors are going to have to be admitting into there if they're going to be treating in a hospital; whether there is an implicit pressure felt from the administration of that hospital that if you keep showing up and demanding that your patients stay in a couple of days extra, you are bucking the administration and that you could run into trouble later on. Is that felt?

Dr. DAWSON. There is implicit pressure. It may not just be from administration and there may not be any significant administrative pressure, but simply an awareness that survival of that hospital depends upon how they handle admissions and discharges.

Mr. WISE. One thing we haven't heard about today is the whole liability question. I would think that has to be quite another wrinkle into this, isn't it? Because you are looking at one kind of liability, the hospital is looking at another. The patient, of course, has the ultimate liability.

Mr. Stutz, returning to my earlier question, and the gentleman from the back said March 24, is it your understanding, then, that all hospitals will be distributing these to patients?

Mr. STUTZ. Yes.

Mr. WISE. So, hopefully, if Mrs. Seeley returns to her hospital, for instance in the next day or so, her husband will hopefully have one of these?

Mr. STUTZ. Should be able to. Yes.

Mr. WISE. I would be interested—

Mrs. SEELEY. Not when I left.

Mr. WISE. Mrs. Seeley, if you wouldn't mind, when you send the gavel back, would you mind also sending a word as to whether or not you have received one of these? I would ask that the record be kept open long enough for that, Mr. Chairman.

And I would like to thank all three witnesses.

The CHAIRMAN. Mr. Vento?

Mr. VENTO. Mr. Chairman, I think it would be helpful for Mrs. Seeley, after she goes through the bureaucracy, to explain how she had to go about getting one of them. It is a disappointment if you have to come to Washington to a committee meeting to learn about these particular rights, which apparently exist in Washington, but don't get very far beyond the Potomac.

Mrs. SEELEY. It is strange that this new doctor I just talked to yesterday morning didn't have one of these to hand to me. He did read—he did say, "Do you know that I just read in our pamphlet that you have 48 hours to appeal?" I said, "Yes, doc, I know about it." But I haven't seen anything in writing.

Mr. VENTO. Did you get a written notice, did your husband receive a written notice in terms of his discharge from the hospital?

Mrs. SEELEY. No.

Mr. VENTO. If you don't get a written notice, you don't have any appeals process. There are all sorts of—even this, which I was just trying to point out in my questioning of the acting administrator of the Health Care Financing Administration, there are a lot of problems. They're supposed to sit down here and talk to the hospital administration about this; of course, consult your doctor. But, in essence, you did that. And that causes some problems.

It also is implicit in this that if the appeals process goes wrong, you could end up with—your husband or whoever the patient is, there for a third day, you could end up getting held with the cost of that one day. And one day in the hospital in Wisconsin is a lot of money, I expect, as it is in our State. You have all the bills there.

Mrs. SEELEY. These are bills, just from my husband. It takes a Philadelphia lawyer to figure them all out.

Mr. VENTO. You figure that maybe it ought to be someone else's job, not necessarily a patient's, I guess, to do that.

Well, Mr. Chairman, I think this is one of the problems in terms of this system, as was indicated, when you get a computer printout of a bill. And then you are assuming that consumers somehow are going to be able to deal with that. I think we have not, in terms of public policy, properly framed the accountability. If that is the accountability we have in the system, it is not very workable.

I appreciate that, Mrs. Seely, and I sincerely hope that this will correct that.

You raised a number of other problems, not least of which may get into legal questions; not that I want to suggest them. But I think there is always that possibility. And we don't expect—I don't think that we should expect that all of these just relate to, for in-

stance, premature release from the hospital. There may have been good intentions. Even with the best of intentions and the best diagnosis and so forth, mistakes do occur. Whether they were reasonable and so forth and so on, I don't know. It is always regrettable when they do. But, nevertheless, they do.

Doctor, I did read your statement quite carefully. I think, Dr. Dawson, it was a very good statement, and I think it points out the sort of information we are looking for. And I applaud your organization, the AMA, and others that are working trying to put some perspective on this particular problem. I think particularly interesting to the committee is the readmission rate, as 84 percent of those that were surveyed feel that they have a higher readmission rate on Medicare patients now—I think it is on Medicare patients pretty much—before—now as they had prior to the institution of the prospective payment system. I think that that is particularly important. And I think that statistically that will probably be borne out in terms of the system.

Would you like to explain to us what is involved in the certification process for the next level of nursing care? You indicate that—there have been a number of indications here by both—I think Mr. Stutz and yourself that that is not quite as smooth as was indicated earlier. Would you agree that that is a more difficult transition than what was intimated earlier in the hearing today?

Dr. DAWSON. Well, I am certain that it is. Certainly in many instances it is.

We would support removing the 3-day requirement before a patient can be transferred to a skilled nursing facility. Often a patient is required to be in a hospital longer than they need to, but it is being done so that the patient can then qualify for a skilled nursing facility.

The appropriate use of skilled nursing facilities and home health care has to be meshed and woven into the whole picture.

I don't know if I'm addressing your question or not.

Mr. VENTO. Yes; I think you are.

How does it relate to the prospective payment system, the skilled nursing type of certification; does that for instance, if a patient—is the change in the amount that is provided to the hospital, if in fact you certify that patient for a skilled nursing facility or not?

Dr. DAWSON. No; the DRG payment is to the hospital. And it does go then—the nursing home payment is made by Medicare, but not from—

Mr. VENTO. Separately and apart from the DRG?

Dr. DAWSON. Separate and apart from the DRG.

Mr. VENTO. I note in your testimony that you also indicated at your hospital they are actually putting stickers on the patient's cart to indicate what his status is. What is the purpose of these stickers?

Dr. DAWSON. That is not in my hospital.

Mr. VENTO. Well, at any hospital.

Dr. DAWSON. Any hospital, that's correct. But they don't do that.

It is to indicate to the doctor roughly how many days they have left before they run out of what the administration perceives as their DRG limit.



Mr. VENTO. So this is not so subtle a message as to how they are performing.

You also indicate fears that doctors will have physician profiles that will be established or could be established which would reflect negatively.

Dr. DAWSON. Yes.

Mr. VENTO. Would you like to explain that, sir?

Dr. DAWSON. Yes; I would be happy to.

Every year, every physician in the hospital has to be recertified or reappointed regarding credentialing for what he may do; both hospital staff appointment, if there have been any changes, any disciplinary actions, anything that has happened, they look at it. And if a doctor does not conform, then he stands to—the risk of losing his admitting privileges and his—whatever his surgical or medical privileges, as well.

Mr. VENTO. And one of those criteria that is used is the length of stay, is that what you are saying?

Dr. DAWSON. It may well be.

Mr. VENTO. It may well be. And is it in any instances, do you know where it is?

Dr. DAWSON. I do not know of any instance personally at this point.

Mr. VENTO. But that would indicate that patients are being over-treated in terms of hospital visits; that is the concern, is that right?

Dr. DAWSON. Yes; that the hospital might say you are using the hospital inappropriately, that "You are costing us too much. You are keeping your cardiac failure too long, way above the average. And we can't afford that."

Mr. VENTO. So, therefore, you would be denied the opportunity to continue using that facility for your patients?

Dr. DAWSON. That's a possibility.

Mr. VENTO. The other point I was just wondering about, I think that very often it is hard for me, being a layperson, to see sometimes where the medical doctor's role ends and the hospital administrators' begin. Maybe that's a good synthesis of having people in charge of working in administration, or at least in that capacity, that are—really have no grassroots knowledge of what is happening in the hospital. That does complicate matters here a little bit, doesn't it, Dr. Dawson?

Dr. DAWSON. Well, it might. I think, though, in some instances that this tension that has been created or aggravated has actually led to better communication between physicians and hospitals.

I think it is good to reiterate that this program is a massive one. It has not been in place that long, and we are still working out some of the problems that have been originating from it.

Mr. VENTO. It seems to me after it has been in place for 3 years that it is sort of incredible that—in fact, over 3 years—it is incredible that there is not clarification on what—discharge of patients would be a key factor. And here we are talking up to 3 years of letting patients know what their rights are, and trying to educate or communicate with medical doctors what their rights are with regard to this, and responsibilities. I am sure there is concern about that. At least the medical doctors I have talked to are concerned about it.



It just seems that we really have opened up a serious problem. One of the concerns here from the beginning is that there would be a premature discharge and, as a result of being conservative with the research—we know hospitals have financial problems, and we knew that to begin with. It seems to me that not having in place some sort of a process, some sort of an appeal mechanism, some sort of safeguards is really irresponsible on the part of the administration of this law. I really think that is the case.

I look forward to the chairman's action on this legislatively. I think it is absolutely essential. I think today we still do not have a remedy and an answer that is satisfactory in my mind's eye.

But I appreciate the problems that medical doctors have had. I think your testimony today will be very helpful to us in pursuing a legislative policy in this matter.

Mr. Chairman, I have no further questions. Thank you.

The CHAIRMAN. Thank you very much.

I would like to thank each member of the panel for the testimony you have given this afternoon. I would like to ask one final question. And that is, how should we interpret the information that under the first year of the prospective payment system the hospital profits have increased? And I ask Mr. Stutz that question first.

Mr. STUTZ. Well, I think you can interpret that as a very short-lived situation.

The CHAIRMAN. But you do agree that they have increased?

Mr. STUTZ. In certain hospitals they have. In some rural hospitals they haven't, and in some city hospitals they haven't. Some of the—and I don't call it profit. We need to make a profit or surplus cash to keep our services going. Money in our hospitals does not go to stockholders; they go to provide care, particularly for the non-paying indigent patient.

I think profits or surplus cash probably increased in the first year simply because hospitals became more efficient and did cut staff and did close units; did stop services that some were—some were nonprofitable or they just found all the efficiencies they could in every area.

I think that has been squeezed out. In this year's blending, we are seeing in our particular hospital a very major budget crunch. We feel we will not be able to, as I have stated before, provide all we have in the past, and that the bottom line of surplus monies is certainly going to shrink. And I think that is true of many hospitals in the country.

So I think it is just too soon to make that assumption that hospitals made—had some windfall profit. That is just not the case. I think it was through efficiency that their bottom lines became larger under that first year, but that is certainly going to decrease.

The CHAIRMAN. Well, the information that we got, Mr. Stutz, in the study that was made, was that the hospitals did do quite well during the first year, that they did in fact make a profit over the previous year and over the previous years. We do not say that that is going to continue. But we did want to know, No. 1, was it true; and I think that it is, I think you have answered that to the affirmative. You have qualified it, however; you said that some have, some not. Well, some businesses make a profit, some do not. But we

are talking about the majority of hospitals. In this instance, the question was related to the majority of hospitals in the United States that do in fact come under this program.

Mr. STUTZ. I think you have to look at where that money goes. In our particular case I am not sure that we made any additional moneys.

For instance, at Albert Einstein Medical Center, at the same time we might have in the first year of prospective pricing become efficient enough to enhance the surplus cash, we had a division, for instance, that I have mentioned, our post-hospital division, that continued to provide unreimbursed care to the tune of over a million dollars.

Again, I would emphasize to the committee, where does that money go in a nonprofit hospital.

The CHAIRMAN. Well, there is nothing wrong with a hospital making a profit.

Mr. STUTZ. It has to, to replace capital.

The CHAIRMAN. It has to. But there is a lot wrong if the hospital makes a profit at the expense of a patient that is discharged earlier and sicker. That, in my opinion, would be wrong. That is what I was referring to.

I thank each and every one of you for your testimony this afternoon. Be sure that the committee will take your testimony under advisement.

I would like to include in the record at this point a statement that was to be made by the gentleman from Texas, Mr. Wright, who was to testify before the committee at this particular time. He is unable to be present. But his testimony will appear in the record.

[The prepared statement of Representative Wright follows:]

## STATEMENT OF MAJORITY LEADER JIM WRIGHT

## HOUSE SELECT COMMITTEE ON AGING

APRIL 10, 1986

Mr. Chairman and members of the committee, thank you for having me here today to address an issue which is of concern to us all. I want to commend the committee on its work to date in investigating reports of premature hospital dismissal of Medicare patients.

In recent months I have received letters and other communication from elderly constituents and their families detailing problems they have encountered with the Medicare payment system.

By far the most disturbing of these are reports of elderly patients being prematurely dismissed from hospitals. Grandfathers and grandmothers, wise and experienced pillars of our community, are being summarily discharged from the hospital before such time as they are medically fit. Many of these patients experience medical complications related to their abbreviated care resulting in yet another trip to the hospital.

One man wrote of his aunt: "Last April my elderly aunt was admitted to the hospital in a very deteriorating physical condition. Nine days later while still very ill, she had to leave the hospital because the Peer Review Board's guidelines required that she leave the

hospital. ...The week of October 30 she was readmitted ... It was necessary that she lie in the emergency room for four hours while extensive tests were administered to justify her admission to the hospital." This woman was discharged shortly thereafter and is now in a nursing home.

Some who contacted me say they have been told new rules passed by Congress were responsible for their having to leave the hospital. They are told that since Medicare payment for their condition has ended they must leave — that this is some kind of government decision. Statements to this effect are shameless falsehoods and should be put to rest immediately.

There is no suggestion, and certainly no legal requirement that an institution discharge a patient who is not medically fit. Indeed, it is unconscionable that such a thing could happen. But, apparently it is happening and I am concerned that it may be widespread.

How did this situation arise? Is Congress at fault? The hospitals? In 1983 Congress instituted our current prospective payment system in an effort to reduce the rate of growth of medical costs and insure the integrity of the Medicare system, while maintaining quality health care. The idea was to curtail wasteful and duplicative procedures and to make health care institutions a partner in the government's efforts to curb the astronomical rise in medical costs.

Under the system, hospitals are paid a fixed amount for each procedure or ailment. If a hospital's costs exceed that payment, the hospital takes a loss. If costs are lower than the fixed payment,

hospitals make a profit. Critics of the legislation said hospitals would go broke under the system — but this has not happened. The Department of Health and Human Services, in a recent review of hospital cost reports, indicated that the average U.S. hospital earned a 14 percent profit from treating Medicare patients in the first year of the prospective payment system. This is more than double the average 6 percent profit margin for other non-Medicare hospital operations.

There is nothing wrong with hospitals making profits — this is the incentive of prospective payment — for institutions to profit from their efficiency. But, if this incentive encourages the unscrupulous few to cut corners, or prematurely discharge patients then we should take another look at the system with an eye toward a remedy for this problem.

Medicare patients, by virtue of their faithful participation in paying into the system, have a right to quality health care. The Medicare system has a mandate from Congress to be as cost-effective as possible, but hospitals, as health care partners should be on guard against the temptation to prematurely discharge patients who are not truly medically ready to leave.

I have asked the committee to include investigation of these reports in this hearing and I am now privileged to introduce someone who has been in the forefront of the effort to call public attention to this growing problem. It is a signal honor to introduce to the committee the next witness, a fellow Texan, Sarah McClendon — the nemesis of Presidents. Sarah has, in her career as a journalist, covered eight



Presidents and I daresay put all of them on the spot at one time or other.

On January 7 of this year Sarah stood at a Presidential press conference and turned the spotlight on this issue by asking President Reagan about the problem of premature hospital dismissal. Obviously Sarah touched a nerve. She has since received letters and phone calls from across the country.

Sarah likes to say that she combines her profession with her citizenship. If we had more citizens like Sarah McClendon the country would be a better place for us all. Mr. Chairman and members of the committee, I give you Sarah McClendon.

The CHAIRMAN. Thank you again for your testimony.  
[Whereupon, at 4:30 p.m., the hearing was adjourned.]

PREPARED STATEMENT OF MARY FISHER, M.S.N., B.S.N., ON BEHALF OF  
THE AMERICAN NURSES' ASSOCIATION, WASHINGTON, DC

Mr. Chairman, I am Mary Fisher, Director of Nursing for the Thomas Jefferson Health District, which consists of five rural counties and Charlottesville, Virginia. I appreciate this opportunity to present the views of the 185,000 members of the American Nurses' Association (ANA) regarding the impact of the hospital prospective payment system (PPS) on the quality of care provided to Medicare beneficiaries.

Our agency nurses have come to realize that while PPS has resulted in more efficient use of health care resources, it has also resulted in patients being released from the hospital "quicker and sicker." Some patients are even being discharged directly from intensive care units while still requiring such complex medical equipment as respirators, suction machines, nasogastric tubes, urinary catheters and continuous oxygen. The hospital nurses and the community health nurses must spend a more extensive amount of time providing to patients and their families the necessary information and instructions that will enable them to maintain safe, competent care in the home.

Mr. Chairman, in your opening remarks at the first in this series of hearings, you succinctly described the delicate balancing act that federal decision-makers must undertake with respect to Medicare. You noted that decisions about Medicare funding must be "consistent with the deficit reduction effort, while ensuring that Medicare remains financially sound and able to meet the health care needs of millions of Americans."

ANA shares your concern that, although the new prospective payment system is still in the process of being implemented, Medicare continues to be a prime target of deficit reduction efforts. While the fiscal year (FY) 1986 budget resolution reduced Medicare outlays by \$2.5 billion for FY86 and by \$11 billion over the next three years, it is anticipated that the Administration will seek additional Medicare cuts in its FY87 budget proposal. The Hospital Insurance Trust Fund, which pays for the hospital inpatient part of Medicare, is currently solvent. Dr. Rudolph Penner, Director of the Congressional Budget Office, in his testimony at an earlier hearing noted that even with a 1% increase in the diagnosis related groups (DRGs) payments in FY86, the trust fund will probably be solvent into the 21st century. Any additional cuts in Medicare funding, however, will disrupt the delicate balance between fiscal responsibility, the provision of quality health care, and adequate access to health care that we all strive to achieve. The burden of deficit reduction should not be placed on members of society's most vulnerable groups who have already borne more than their fair share of budget cuts in recent years.

While the specific impact that PPS has had on the health care delivery system is still under evaluation, preliminary research findings and anecdotal evidence already available indicate that, in addition to the effect that PPS has had on hospital services, it has also had a significant impact on non-hospital community health services. A 1985 preliminary report from the U.S. General Accounting Office addressed the impact of PPS on post-hospital care. The report stated that there has been an increase in the use of nursing home and home health care services by Medicare beneficiaries.

The fact that changes in the hospital reimbursement structures have had a ripple effect on community health services can be explained by the "balloon theory." When you squeeze the middle of the health care "balloon" by shortening hospital lengths of stay and discharging hospital patients at reduced functional levels, you enlarge both ends of the health care "balloon" - meaning that there is an increase in the health care services being provided both pre-hospitalization and post-hospitalization. As the providers of the largest proportion of client care in the community health arena, community health nurses are in a unique position to see the extra-hospitalization impact that PPS has had on the quality of care provided to Medicare beneficiaries.

Several nursing colleagues and I recently completed a two-stage study, which was partially funded by a grant from the Department of Health and Human Services. The impetus for this study came from reports by local public health nurses in the spring of 1984 of a shift in patterns of care from more routine care for diabetics and indwelling urinary catheters to more complex care including indwelling arterial-venous catheters and intravenous antibiotics. There appeared to be a need to document these kinds of changes in referrals and patient needs in order to plan manpower and service responses. Two questions were addressed in the study: 1) Are there changes in patterns of referrals from hospital to home health care? 2) If so, what are the direction and magnitude of these changes? The study describes observed changes in home health nursing service referral patterns and associated nursing service changes. Stage 1 looked at all referrals for home health from a small community hospital in Virginia for six months before and after DRGs. Stage 2 looked at referrals for home health from a medium-sized acute care/general medical and surgical hospital in Virginia for six months before and after DRGs.

The most significant finding from Stage 1 of the study was that:

- Home health care patients required significantly more frequent visitation and more intense nursing services after the implementation of DRGs. Requests for daily visits rose from 11% pre-DRG to 22% post-DRG; requests for visits three times per week rose from 0% pre-DRG to 11% post-DRG. The intensity of nursing services also increased from a pre-DRG mean of 2.22 to a post-DRG mean of 2.83.

The abstract of the completed research from Stage 2 of the study will be presented soon. Analysis of nursing resource consumption in Stage 2 confirmed

Stage 1 findings that home health care patients required significantly more frequent visitation and more intense nursing services after the implementation of DRGs in the primary referral hospital.

Another recent study drew similar conclusions. The 1985 study by the Southwest Long Term Care Gerontology Center at the University of Texas Health Science Center at Dallas, in cooperation with the National Association of Area Agencies on Aging, reported the findings of a national survey of Area Agencies on Aging concerning changes in service demand and service delivery patterns under DRGs. Area Agencies on Aging are mandated by Congress to plan and coordinate all community-based services for older adults.

Major findings in the report indicate that after the implementation of PPS:

- There was a major shift in service delivery patterns. Case management services increased 365%, in-home skilled nursing increased 196%, housekeeping services increased 69%, and personal care increased 63%.
- The length of time and number of visits per client both increased. This trend is more dramatic among those agencies where DRGs have been in effect the longest. Some agencies have been forced to cut number of service units per client in order to provide services for a longer period of time.
- The greatest demand on agencies by hospitals was for coordination of multiple community services for older persons and their family caregivers, and for personal care services.
- Inadequate family support was a major reason for readmission to hospitals. It is this one service area, however, for which a decrease in service units was documented.

A recent congressional study yielded similar findings. In March 1985, the Task Force on the Rural Elderly of the House Select Committee on Aging released the results of a Prospective Payment Survey sent to State Long-Term Care Ombudsmen. These Ombudsmen oversee problems of patients in nursing homes and are paid by the Administration on Aging.

The results indicated that problems regarding quality health care and access to health care, especially in rural areas, appear to have been exacerbated with the introduction of PPS. Specific findings include:

- An overwhelming majority said patients are discharged sicker than before PPS and, therefore, more were in need of skilled nursing care.
- Existing skilled nursing services are not adequate to meet the needs of discharged patients in all cases.
- It is increasingly difficult for patients to find skilled nursing facility beds or secure necessary home health care.

While studies and surveys provide helpful information, I believe the following anecdotal evidence will vividly highlight the types of problem situations involving Medicare patients that our nurses are encountering:

1. Late referrals are being made by hospitals to the community health agency.

Case History: A 62 year old disabled man with acquired immune deficiency syndrome (AIDS) and diminished mental capabilities was discharged from the hospital on a Saturday. There was no agency referral from the hospital until Monday. While the hospital nurses had provided some instructions to the patient and family on prevention of the spread of AIDS virus through



properly handling of his body fluids, the devastating nature of this disease required time for extensive education and adaptation by the patient and family to the home environment. Without adequate education about the ways to prevent the spread of the AIDS virus to family members, there was an increased risk of disease transmission to the rest of the family. AIDS has been declared America's number one public health priority by the Public Health Service and thus necessitates that proper patient and family education be provided. Late referrals decrease the time available for sufficient instruction of the patient and family and preparation of the home environment.

2. Patients are discharged home, sometimes directly from critical care units, with complicated equipment requiring highly technological care.

**Case History:** A 68 year old woman with amyotrophic lateral sclerosis (Lou Gehrig's disease) and nine additional diagnoses was discharged home directly from the medical intensive care unit, with 13 pages of care instructions for her family. She had a tracheostomy and was on a ventilator, required tube feedings, was on nine medications (including an anticoagulant medication that involved daily injections) and needed special skin care. No nursing home would take her because she was respirator-dependent. She was, therefore, totally dependent on her husband and one of her children for care beyond the daily and sometimes twice a day visits by the community health nurse. This dependency had a very negative impact on the family, to the degree that officials from the protective services agency had to be called in to deal with spousal abuse. While cases of spousal abuse are rare, many families experience frustration and guilt at their inability to provide the highly technical care that the patient requires.

Prior to PPS, this woman probably would not have gone home before her death from ALS. The increased level of care, sometimes critical care, that patients now require post-hospitalization is placing great demands on community health nurses. In some instances, unfortunately, lesser-prepared health personnel are being hired to perform highly technical procedures that they are not qualified to perform. Community health patients have a right to receive safe, competent health care.

3. The "dumping" of non-profitable patients by for-profit home health agencies.

**Case History:** A 23 year old woman who was mentally retarded, diabetic, obese and hypertensive developed a very large leg ulcer. A for-profit home health agency was willing to care for the woman when her condition only required a dressing change. When it became apparent that there was a possibility that she might lose her leg, and the need for control of diet, hypertension, and diabetic behavior modification warranted more complex care. Because this complex care was not a covered benefit, the for-profit agency refused to continue to provide services. Fortunately, our agency was able to provide the intense case management that was required because of the involvement of the physicians, the hospital and other services. This woman is no longer in danger of losing her leg. She is now living in the State Training School for the Mentally Retarded where she is receiving the help she needs to control her complex medical problems.

The impact of PPS on the quality of care provided to Medicare beneficiaries was the topic of a recent Senate hearing. The September 26, 1985 Staff Report of the Senate Special Committee on Aging on the "Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries" made the following findings: seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals; hospital patients who live alone and are too sick to appeal hospital discharge decisions are without any protection under PPS; many patients, especially the terminally ill and their families, are being given false and incomplete information on their rights of discharge appeal and on options for post-hospital care; and some hospitals have denied admission to patients with multiple serious conditions.

The American Nurses' Association has several recommendations for improvements in the current status of Medicare, the first two of which are similar to recommendations contained in the Staff Report of the Senate Special Committee on Aging.

1. Peer Review Organizations (PROs) should be mandated to do more quality assurance monitoring and enforcement activities, especially as it relates to inappropriate and premature discharges.
2. The DRG classification system should be changed to better reflect differences in severity of illness between patients in the same DRG category so that hospitals receive sufficient payment to provide adequate care.
3. Services such as counseling, health education and other health prevention services should be included as covered home health benefits.
4. The onset of PPS has placed such great demands on the community-based care systems, that the current level of community-based services available to Medicare beneficiaries is inadequate to handle their health needs. This fact should compel Congress to increase the community resources available to satisfy the increased need. Development and use of alternative health care delivery systems, such as freestanding nurse-managed centers, is one viable option.
5. Congress should request that a study be done on the impact that PPS has specifically had on community-based care systems.

In summary, when policy and funding decisions for Medicare are debated, cost containment must be balanced with quality of care and access issues. For if we control costs at the expense of the elderly, our health care policy is nothing less than a failure.

Mr. Chairman, ANA appreciates your consideration of our views and looks forward to working with you on this issue.

# HOMECARE

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April 28, 1986

Congressman Edward R. Roybal  
Chairman, Select Committee on Aging  
U.S. House of Representatives  
Room 712, HOB  
Annex #1  
Washington, D.C. 20515

Dear Mr. Chairman:

The National Association for Home Care (NAHC), the nation's largest association representing home care professionals and paraprofessionals with nearly 3,000 member organizations, is pleased to offer comments on the experience of the home care industry concerning the topic of this important hearing, "Soon and Sicker, Myth or Medicare Crisis?" Without question, DRGs have had a profound effect on the types of patients seen by home health agencies (HHAs). Unfortunately, this change has occurred at the same time the Administration has undertaken a systematic effort to dismantle the Medicare home health benefit. The following is a brief analysis of the impact DRGs are having on the home health industry and the impediments to rendering service that have been initiated by the Administration.

## Impact of DRGs on the Home Health Industry

The implementation of the hospital prospective payment system has had a dramatic impact on the home care industry, both in terms of the acuity level and the number of patients needing home care after a hospital discharge. In addition to the volume of anecdotal evidence from home care providers relating that patients are being released from hospitals "quicker and sicker" since the implementation of DRGs, there have now been several studies documenting this occurrence. Last fall, in response to a request by Senator John Heinz, Chairman of the Senate Special Committee on Aging, the General Accounting Office (GAO) prepared a report which concluded that under the DRG system, patients were in fact being released from hospitals more quickly and in a sicker condition and found that discharges of hospital patients to HHAs had increased in over 83 percent of the agencies surveyed. The Eastern Washington Area Agency on Aging (EWAAA) in Spokane, Washington recently conducted a study on the effect of DRGs on community based agencies in Eastern Washington State. This study concluded that home health agencies are bearing the brunt of the effects of earlier discharges under the DRG system. The study found that under the DRG system, the number of reimbursable home visits rose 27% for urban home health providers, based on six month data for comparable periods during 1983 and 1984, and that professional nursing visits rose 37% in urban areas and 18% in rural areas. In response to the increased acuity of patients being seen in the home, the study found that home care providers are:

- \* Purchasing or planning purchases of more sophisticated equipment such as intravenous pumps and hospital beds.
- \* Securing training for personnel on topics ranging from the use of more sophisticated medical equipment and devices to the performance in the home of complicated nursing procedures.
- \* Experiencing an increase in the use of traditional nursing supplies such as skin care products, gauzes, irrigation sets, and intravenous kits.
- \* Experiencing an increase in the demand for the delivery of rehabilitative services, especially speech and physical therapy services.
- \* Experiencing an increase in the growth of staff nurses, aides, and office personnel. At one agency, the number of full-time RNs rose from 11 to 45 between June 1983 and June 1984, home health aides increased from 17 to 25 FTEs, and physical therapy staff increased from one to two members.

A study conducted by the Home Health Assembly of New Jersey documents similar results. In 1980, New Jersey became the first state to implement a prospective payment system for hospitals based on DRGs. The New Jersey study found that:

1. The DRG system in New Jersey has increased the number of hospital referrals to home health care.

New Jersey's hospitals were phased into the DRG system over a three year period: 1980, 1981 and 1982. According to the New Jersey Health Department the average length of stay in 1979 (pre-DRG) for the seven most common types of licensed hospital beds was 7.43 days; this figure dropped to 7.0 days in 1982 and decreased farther, to 6.39 days in 1983. (By comparison, the Department of Health and Human Services reports a reduction in average length of stay in the Medicare program from 9.5 days to 7.5 days after the first full year of the federal prospective payment system.)

In a data report, compiled in cooperation with the New Jersey Department of Health, the Home Health Agency Assembly of New Jersey found that the number of admissions to home health agencies from hospitals jumped from 61% to 68% of total admissions between 1980 and 1981, the first year of phase-in for the DRG system in New Jersey. Since 1981, hospital referrals have remained a constant 67% of total admissions for home health care. The net impact of the DRG system is an increase of 8,000 admissions to home health care in 1983. There were a total of 133,000 persons served by home health agencies in New Jersey in 1983.

2. Home health agencies have greatly increased their provision of high technology care in the home in order to respond to the earlier discharges.

Over the same four year period during which the average length of stay steadily dropped, the number of high technology services offered by home health agencies grew dramatically. According to 1983 data, the following services were offered by a significant number of home health agencies:

#### TYPES OF PROGRAMS AVAILABLE (1983)

|                                      | NUMBER | PERCENT |
|--------------------------------------|--------|---------|
| Home Catheter Care                   | 50     | 98.0    |
| Tracheostomy Care                    | 45     | 88.0    |
| Intravenous Therapy                  | 26     | 51.0    |
| Respiratory Therapy (MIA Respirator) | 17     | 33.0    |
| Chemotherapy                         | 13     | 25.5    |

The growth in high technology services experienced over the period paralleling the DRG implementation years suggests a relationship between the two events, explained by the introduction of more acutely ill patients into the home health care setting.

3. Home health agencies have expanded their hours of operation to meet hospital discharge requirements.

The trend to expanded hours of operation, both business hours and service hours, is the most striking change in home health agency operations since the implementation of the DRG system. Eighty-two percent of home health agencies in New Jersey schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock. Four years ago, only 66% of the agencies offered evening and weekend coverage.

Other studies have been released recently that provide further evidence that DRGs are causing earlier discharges of patients who often have not been given sufficient time for their conditions to stabilize. A study of data from the Health Care Financing Administration, conducted by the Senate Special Committee on Aging reported a 37 percent increase in discharges from hospitals to HHAs because of DRGs. A study by the Southwest Long Term Care Gerontology Center observed a 196 percent increase in HHA skilled nursing services that had to be provided after DRGs. University of Virginia researchers reported on the 27.5 percent increase in the intensity of home care services needed by beneficiaries because of DRGs. In a survey recently conducted by NAHC of 2,100 Medicare-certified HHAs, 92 percent responded that DRGs had resulted in a sharp increase in the number of sicker patients requiring intensive medical or nursing care. Finally, the Office of the Inspector General released a report in March, 1986 finding that "it is apparent that occurrences of premature discharges and inappropriate transfers do exist." There is no longer any question that DRGs are having a very significant effect on the need for more intensive home care services.

#### Impediments to the Delivery of Home Care Services

Despite the documented increase in demand for home care services created by the DRG system, the Health Care Financing Administration has sought to curtail the Medicare home care benefit, citing this very increase in use of home care services as justification for developing excessively stringent regulations and

policies to govern the home health program. The following administrative actions recently undertaken by HCFA illustrate some of the impediments to the delivery of home care services to Medicare beneficiaries:

- \* New coverage compliance review (CCR) criteria were issued in December 1984, establishing review on a non-random sample basis and placing increased scrutiny on "homebound" status and home health aide utilization.
- \* A manual revision was issued in April 1985 which allows fiscal intermediaries to use statistically invalid and unreliable sampling techniques to select a sample of claims for review to determine an agency's waiver status.
- \* A new set of "minimum data element" forms (HCFA Forms 485-488) have been implemented which will increase the level of claims undergoing medical review to over 50 percent. Due to a poorly-designed set of computer specifications for use in processing these forms, intermediaries will be performing the increased level of medical reviews on a mainly manual basis, thus slowing down claims processing and cash flow.
- \* A new standard billing form (HCFA Form 1450, also known as UB-82) must be implemented by all HHAs by no later than October 1, 1985. In many instances, system design and implementation problems have caused or will cause significant claims processing backlogs, affecting HHA cash flow and ability to render services.
- \* In the midst of implementing the new data element forms and billing forms, HCFA will be instituting a new regional intermediary system shifting 85 percent of all HHAs from their current intermediaries (there are 47 statewide intermediaries now) to a regional system of ten intermediaries.
- \* An accounting policy on "discrete costing" is in effect which discourages HHAs from diversifying into non-Medicare program areas at the risk of having the non-Medicare programs absorb a disproportionate share of overhead created by the Medicare program.
- \* On July 5, 1985 HCFA established a new schedule of cost per visit limits for HHAs based on highly questionable data and methodology and inappropriate notice which will have the effect of closing many HHAs; severely limiting agencies ability to deliver many services, particularly in rural areas; and limit many agencies ability to deliver indigent care and "hi tech" care.
- \* HCFA proposed, in President Reagan's FY 1987 budget, to impose a copayment equal to one percent of the inpatient hospital deductible. If implemented for FY'87, this would mean beneficiaries would pay a \$5.00 copayment for each of their home health care visits.
- \* A January 1984 manual change prohibits beneficiaries from designating HHA employees as their representatives in claims denial appeals. This policy is being challenged by NAHC in a lawsuit.
- \* A policy has been instituted creating the legal fiction of a "technical denial" which prohibits HHAs from appealing any claims denied on a "technical denial" basis.
- \* A policy has been instituted whereby HCFA, through its intermediaries, use a questionable sampling methodology to sample claims and project the denial rate to an agency's entire caseload resulting in a demand for repayment prior to any appeals. NAHC has initiated a challenge to this illegal policy which already has resulted in a favorable Administrative Law Judge ruling in New Mexico.
- \* HCFA will not pay for home intravenous antibiotic therapy supplies, equipment or services.
- \* HCFA will pay for home intravenous chemotherapy supplies, equipment and services only on a limited basis.
- \* The regulations governing the Medicaid 2176 Home and Community-Based waiver programs, designed to encourage states to broaden Medicaid home coverage for targeted needy populations, were revised March 13, 1985 creating onerous new paperwork requirements and qualifying standards so as to discourage states from participating.

In addition, one of the biggest problems facing HHAs under Medicare at present concerns widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted. Delays of well over 120 days have been reported this year by home care providers throughout the country. The resultant cash flow problems that this has caused has rendered numerous providers unable to meet their payrolls. To date, we have received reports from the states of California and Illinois that several providers were forced to put their agencies up for sale because of this problem. In a survey conducted recently by the Louisiana Home Health Association, 18 percent of the respondents reported that they had not received Medicare payments in over 120 days. Two agencies reported that they were owed more than \$300,000 each. In Oklahoma, many agencies received denial notices in March 1986 for services rendered and claims submitted in November 1985.



After an agency submits a claim for payment, it continues to provide Medicare services even if payment is delayed extensively. If the claim is denied months after it is submitted, the agency may well have incurred additional expense for months of additional services. However, the agency is not permitted to turn around and bill the patient for the services rendered. Rather, the facility must take a loss, or "eat" the cost. Thus, when coverage determinations are delayed, thousands of dollars worth of potential revenues are lost; whereas, if determinations are made promptly, within 30 days, the agency has the option of billing the patient for subsequent services and is not forced to take such massive losses.

Finally, NAHC is also concerned that further shortchanging of Medicare beneficiaries will result if HCFA uses outdated cost data from FY 1983 cost reports to set HHA cost limits for cost-reporting periods beginning after July 1, 1986, as it evidently intends to do. First, these data fail to reflect the costs incurred by HHAs in treating sicker Medicare patients discharged earlier from hospitals under prospective payment, which did not go into effect until October 1983. As more intensive care is being provided under the home care benefit, the cost per visit obviously has increased.

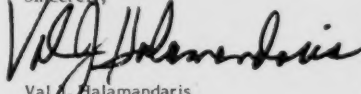
Furthermore, the 1983 cost report data also fails to take into account the experience of agencies that have entered the Medicare program since October 1982, as well as the costs that agencies have had to incur in complying with HCFA's new medical documentation requirements -- an administrative cost associated solely with billing for Medicare-covered services, which should appropriately be borne exclusively by the Medicare program.

Not only is HCFA intending to use an outmoded data base that no longer reflects the cost experience of HHAs providing care today, but HCFA plans to ratchet down last year's cost limits to 115 percent of the mean cost per visit per discipline on July 1, 1986.

Unless Congress intervenes to prevent HCFA from basing reduced limits on stale data, access to the Medicare home health benefit will be seriously eroded at a time when the demand for such services is growing because of other changes in the health care delivery system. NAHC proposes that Congress act immediately to prevent HCFA from implementing lower cost limits based on FY 1983 cost report data and that HCFA be required to process expeditiously the FY 1984 cost report data so that newer and more accurate cost data can be used in computing appropriate cost limits.

We appreciate this opportunity to submit our views to the House Select Committee on Aging. We urge that Congress act to address the problems articulated above. A first step would be to enact legislation authored by Chairman Roybal (H.R. 4330), and Congressman Stark, (H.R. 4638). We look forward to working with the Committee on Aging to ensure that Medicare beneficiaries receive the home care services they have been promised under law.

Sincerely,



Val A. Malamandaris  
President